UNITED STATES DEPARTMENT OF DEFENSE

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TASK FORCE ON THE CARE, MANAGEMENT, AND TRANSITION OF RECOVERING WOUNDED, ILL, AND INJURED MEMBERS OF THE ARMED FORCES

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JANUARY BUSINESS MEETING

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TUESDAY

JANUARY 28, 2014

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The Task Force met in the Washington Ball Room of the DoubleTree Hotel Washington D.C.-Crystal City, located at 300 Army Navy Drive, Arlington, Virginia, at 8:30 a.m., Suzanne Crockett-Jones and Matthew L. Nathan, Co-Chairs, presiding.

PRESENT

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair
VADM MATTHEW L. NATHAN, DoD Co-Chair
CSM STEVEN D. DeJONG
RONALD DRACH
TSGT ALEX J. EUDY
LT COL SEAN P.K. KEANE
KAREN T. MALEBRANCHE
MG RICHARD P. MUSTION
STEVEN J. PHILLIPS
DAVID K. REHBEIN

ALSO PRESENT

DENISE DAILEY, Task Force Executive Director
BRANDI BARNETTE
MARION CAIN
FRANK C. DiGIOVANNI
SHARI ERICKSON *
KEN FALKE
JOHN HANSON
YVONNE HARRINGTON *
DARCY HOTCHKISS
JIM LORRAINE
DERENDA LOVELACE
CHRISTOPHER MILLER
MICHAEL PARKER
TERESA PIERCE *
GINNEAN QUISENBERRY
PATRICIA REILLY *
JOHN RICHARDSON
CAPTAIN STEPHEN SEARS
RICHARD WILLIS

* Present via telephone

C-O-N-T-E-N-T-S

C-O-N-T-E-N-T-S (CONTINUED)

C-O-N-T-E-N-T-S (CONTINUED)

C-O-N-T-E-N-T-S (CONTINUED)

P-R-O-C-E-E-D-I-N-G-S

8:31 a.m.

CO-CHAIR CROCKETT-JONES: Welcome, everybody.

This morning we have two oral statements for contribution to our public forum.

We welcome Mr. Michael Parker, a Wounded Warrior advocate, to provide his statement to the Task Force. The members can find Mr. Parker's information in the front of tab H.

Good morning, Mr. Parker. I'm turning it over to you.

MR. PARKER: Good morning and thank you.

At the October 2013 business meeting, the Recovering Warrior Task Force received a brief from Mr. Jim Davis of the Physical Disability Board of Review. Part of that brief covered the PBR Special Review Panel, which reviews past mental-health-based

DES cases to ensure they were properly adjudicated.

I recently received the results of an SRP review. The contents demonstrate that the SRP process is fatally flawed and will do little to ensure proper compensation of wounded warriors with mental health issues.

Troy Balke is an Iraq war veteran with over 10 years of service who underwent a MEB and a PEB for both physical and mental health issues. Despite being diagnosed for PTSD while on active duty, his MEB and his PEB changed his PTSD to a non-compensable diagnosis of adjustment disorder with anxiety and depression.

The outcome of the SRP process is an advisory opinion to the Board for the Correction of Military Records. Troy Balke's SRP advisory opinion is arbitrary, capricious, and very much one-sided. It leaves out critical information that clearly demonstrates that Troy Balke suffers from severe PTSD which

is unfitting.

The SRP admitted that Troy Balke was diagnosed with PTSD while on active duty. However, the SRP stated that, since both his MEB and PEB classified the mental health issue as adjustment disorder, Troy Balke was not disadvantaged by the process. In other words, as long as the MEB and the PEB are consistently wrong, there is no problem, and this is absolute BS.

In addition, the SRP opined that Troy Balke's mental health issue was not unfitting. Nothing could be further from the truth. Two key elements that the SRP conveniently left out of their advisory opinion is Troy Balke's VA and Social Security determinations.

The VA rated him 100-percent disabled, permanent and total, for PTSD, effective the date of separation. The VA based this rating on an extensive list of issues, to include total occupational and

social impairment, disorientation to time and place, persistent hallucinations and suicidal ideations.

The Social Security Administration deemed Troy Balke totally disabled due to physical and mental conditions, with an effective date 15 months prior to his separation from active duty.

Troy Balke's 100-percent PTSD rating decision specifically mentions his Social Security determinations, but the SRP made no mention of these facts in their advisory opinion. This leads me to conclude that the SRP structure, procedures, and culture will not honestly evaluate mental health issues. Rather, the SRP is designed to do the least amount possible, and they will be a part of a chain that cheats Wounded Warriors out of proper DoD disability benefits.

Time limitations prevent me from sharing other concerns and issues with the SRP. To that end, I have attached an

information paper to this statement summarizing these concerns and issues.

I have also attached key documents from Troy Balke's case for your review, and this includes his 100-percent VA PTSD rating and his Social Security determination.

I'll be happy to entertain any questions or issues you may have.

CO-CHAIR CROCKETT-JONES: Actually, I have a question. Did this happen in the legacy DES or in the IDES?

MR. PARKER: His initial PEB was a legacy case. So, the VA was involved, but not -- as a parallel process, he applied for benefits delivery at discharge and was actively getting his VA rating while he was still on active duty, but it wasn't as part of the IDES. It was a separate action.

CO-CHAIR NATHAN: Mr. Parker, when you and/or Mr. Balke went to lengths to try to reconcile this with the PEB, did you get any kind of answer for them? In other words, if

the PEB were here or the cogent representatives of that, and we asked them, "Why the discrepancy between what he was diagnosed with before he came to you and your change to an adjustment disorder?", what would they say?

MR. PARKER: Well, I was not involved in this case at that time. His case was adjudicated in 2010, and he just recently reached out and touched me about two months ago.

And that was because the PDBR sent him a letter saying, "You're eligible for this review," which was part of the whole issue of adjustment disorder and personality disorder being used in lieu of PTSD. So, he got flagged for that.

The SRP grabbed all his records and, again, the output was to do this advisory opinion. So, all I am basing this on was the record. I have never met Troy. I have talked to him on the phone several times. I wasn't

part of his case back then. But I have looked at his VA, his Social Security, and the other documentation that he has, to include the SRP. The SRP was the one that confirmed that he, in fact, was diagnosed with PTSD while on active duty, which triggered a MEB.

CO-CHAIR NATHAN: Was he one of the individuals who came through the Ft. Lewis-McChord group?

MR. PARKER: No, he was not at Ft. Lewis-McChord. He was in the Kentucky area, if I remember right.

CO-CHAIR NATHAN: Okay.

MR. PARKER: But it was a similar thing, and his SRP, which puts an advisory opinion out to ABCMR, and the ABCMR, he gets a letter saying, "You now have 30 days to rebut it," and we're in the middle of rebutting it right now, as to why the SRP didn't do everything they should have done. But that's the records we have.

The SRP, if you look at it, it

says, "We have a case file, and our decisions are based on that case file," well, Troy doesn't have that case file yet. We have requested it, so that we can make an appropriate rebuttal. We can't really rebut it in full without knowing exactly what the SRP looked at. Because they mention it and say, hey, based on the information in the SRP, this, or on the case file, but we're blind to the case file at this point.

CO-CHAIR NATHAN: So, if I can infer from what you're saying, two main points. One is that, from a tactical perspective, you believe that his ultimate finding of disability by the Social Security Administration and by the VA lends weight to the fact that he does have a disability, a Disabling Post Traumatic Stress, that was not captured by the MEB and the PEB process? So, that, one, they just simply got it wrong in your opinion.

No. 2 is that, even if they got it

wrong, you don't believe there is a viable mechanism that exists for him to go back and get that corrected?

MR. PARKER: Well, I would couch it as there is an array of evidence out there. And the SRP based their advisory opinion on the evidence that supported what they wanted, which was not to have a change in decision. And for them to leave out his VA ratings in that advisory opinion and to leave out the Social Security determination in that advisory opinion is the foul ball. They can't go through this review process and them to give a one-sided story with only the evidence that supports the position they wish to make.

CO-CHAIR NATHAN: Any other questions or concerns?

(No response.)

Thank you, Mr. Parker.

MR. PARKER: Thank you.

CO-CHAIR CROCKETT-JONES: We now welcome Mr. John Richardson, a Navy Reservist

and Wounded Warrior, to provide his statement to the Task Force. Members can find Mr. Richardson's information behind Mr. Parker's information in tab H.

I'm turning it over to you, Mr. Richardson.

MR. RICHARDSON: Thank you. Good morning.

My circumstances are the same as stated when I appeared before you in October of last year. Therefore, I would like the same information submitted for the record again.

There is one exception, however. The Social Security Administration, specifically the Disability Department, has reviewed my military and civilian medical records and also determined that I should be retired on disability.

This is the third government agency, the first being the Navy and the Veterans Administration, to review my injury,

medical condition, and confer my original diagnosis as well as documentation from numerous medical professionals.

For your information, the Social Security Administration has a higher standard of proof than the Department of Labor and the Office of Personnel Management.

Again, I am entering my third year of limbo. I am unable to completely and permanently retire and begin the next phase of my life. I know that Mr. Jeh Johnson is now Secretary of DHS.

There were five things that I asked for when I appeared before you before. And again, permanent military retirement at the appropriate rating, restoration of the promotion that I lost. I was selected for promotion to Commander, but because I ended up on the TDRL list, a designation that this Task Force has asked Congress to eliminate, my promotion was taken from me. So, that's rubbing salt in the injury that I suffered on

active duty.

And any sort of email or letter of support asking DHS to simply allow me to retire.

Oh, and then, also, again, the way my injury occurred, as described in several statements, was via wearing the body armor in pre-deployment combat training. Again, I injured myself, did not know the extent of my injury, completed my deployment, and followed my doctor's recommendation to retire. I'm on this road because my doctors told me, "It's in your best interest to retire."

And then, finally, I would like to have a retirement ceremony. After 30 years, I think I have earned it.

Again, if I have some time, I need you to know that my father is buried at Quantico National Cemetery. He was a World War II veteran, Pacific Theater Ribbon. He was one of the first African-American Seabees. My father-in-law was one of the first African-

American hospital men, corpsmen. My grandfather was a medical doctor. My family has contributed to this country.

And I would like to be able to go back and tell the neighbors that have written emails of support to you, I would like to be able to tell my mother, I would like to be able to tell my children that I'm not going to be lost, that I'm not going to be another statistic.

I cannot imagine being on active duty and having a junior person come to me and ask me for help, and several months later that person has to come back to me again and tell me the same story. I cannot imagine in the duties that I have performed telling someone that I would facilitate something to get them out of trouble, and then not do it.

My story is real. I'm a real person. What has been done to me, the effects are cross-generational. I support not just my elderly mother, but I have nieces and nephews

who depend on me for book money, for car money. So, I really need you to understand that I need your help. I'm a real person and I have real problems.

And again, I submitted for the record a letter from Congresswoman Duckworth, whom I have reached out to, and even from her military liaison, it is very clear that there is still confusion as to what my status is.

So, I am here again asking for your help. Thank you.

CO-CHAIR NATHAN: So, Commander Richardson, no one questions that your family has been very dedicated in a heritage of service to the country.

You currently are in your third year of TDRL status?

MR. RICHARDSON: I am, yes, I am in -- this is, when I came back, my deployment was from September of 2010 to 2011, Admiral. And so, I began that process of becoming a disabled veteran, but coming back and

reporting to my civilian job and having every single federal disability, USERRA, every violation in the book being done to me. That, again, adds to the same problem.

So, basically, for me, this is my third year of just limbo. I'm not able to work. I am not able to even volunteer. I can't go to training. Anything that I do right now in the limbo that I am in puts me in some sort of jeopardy.

And I need to talk with you and Ms. Crockett-Jones off the record.

And I can tell you, DHS, which is part of, in my opinion, our defense, what I am dealing with at DHS is nothing more than corruption and cronyism. That's what is keeping me from retiring.

CO-CHAIR NATHAN: I'm trying to understand a little bit about the difference in your situation. And you're correct, the Task Force has gone on the record as saying that the TDRL system probably creates more

bureaucracy than it solves. That said, it is still in existence.

What do you see at the endpoint? What are you being told by the people who are following you and doing your periodic physical examinations that are required under the TDRL process? At the five-year point, when you reach the term limit of the TDRL, what do they anticipate will happen?

MR. RICHARDSON: Well, I did talk with one of the TDRL lawyers. He discouraged me from actually asking to go to the Board early.

My doctors, every single person that the Navy referred me to, including Dr. Steven Hughes, who is a renowned back surgeon in the D.C. area, have all uncategorically said, "This gentleman's injury, he should retire."

So, my concern is I am supposed to go back for the TDRL Board this spring. And everything that I have been told about that,

it is anecdotal information, but all of the professionals that I have talked to, they say that is a business decision. "Your medical condition is going to be secondary to the business decisions of that TDRL Board."

And quite frankly, I fear going before them in this status where I have asked people in Congress, I've asked this Task Force for help. My fear is going before them, and they reduce my benefits right now, at a time that I just cannot afford that to happen to me.

CO-CHAIR NATHAN: So, if someone were to say to you, "Look, we're just going to kind of flip all the cards over now at the three-year point, instead of the five-year point, and put your MEB through to the PEB for medical retirement," that's what I heard you say initially. But now I hear you saying you worry about that because you might receive a lower disability rating than you deserve.

MR. RICHARDSON: Well, my concern

is based on what I have been told. To be honest with you, there are so many things that I am dealing with, including the effect that my injury has on me in terms of just concentration in pain as I am standing before you right now.

I don't know what to do. I cannot adequately answer your question right now because I would only be parroting back to you the things that I have been told by others. And I don't know how accurate or inaccurate what I have been told actually is.

I know that the documentation that I currently have on hand from a number of medical professionals that span my original diagnosis in July of 2011 up until now are exact same, with the exception of my condition has worsened. But the original diagnosis from the doctor that I saw at Camp Lemonier, it has been consistent.

Everything that the medical professionals have written about me has been

consistent. So, my condition, as documented, is still the same. I just don't know what else I can do to show that I need to be permanently retired. I'm willing to do whatever this Task Force or whatever someone that I am given to to act as an advocate, I am willing to do whatever they want me to do. But, as of right now, the phone calls and the emails that I have sent out to various individuals whom I was told to contact, it just seems as though I have fallen through the cracks again.

CO-CHAIR NATHAN: Okay. Well, I understand the bureaucracy can be very confounding. What I hear you saying is that you suffered an injury. The injury was such that it was not consistent to leave you on active duty. You were not sent for a PEB at that time. You were put in a temporary disability limited-duty status, a TDRL, which is designed, whether it is the right way to do it or not, is designed to monitor the status

of your injury or illness, determine if it improves or deteriorates over time. If it does not improve to the point where you can return to active duty, then at the end of the TDRL period, you are to be retired medically. And you will go through a disability evaluation, and if there is compensation based on that from the VA system, you'll get it.

What I hear you saying is, "Look, I had this condition three years ago. They put me on TDRL. There's medical documentation that I'm no better now than I was then; in fact, worse. I just wish they would fish instead of cutting bait all the time and put me through the disability system."

But, then, I hear something a little confusing from you. "But I fear doing that now because I'm worried they won't give me the compensation to which I am due."

MR. RICHARDSON: Understood. That fear is based on appearing before the TDRL Board again. I think the TDRL process was the

most expedient process to getting me out of the system, to getting me out of Norfolk MEDHOLD East, to be honest with you. I think that was the path of least resistance.

Had I known then what I know now, and even going back and remembering what one of my PEBLOs or what one of the VA reps said to me, I said, "Well, how is my condition going to improve?" And she said, "Well, you're right, very rarely do back injuries improve. So, this is what we're going to do for you right now. Later on down the line, you'll be permanently retired."

But, again, having gone through this process right now, I know more than I knew then, but, ultimately, my concern is this: if I was a younger, less mature, less experienced, less trained person, I can tell you right now, Admiral, I would have checked out by now. I would have become another statistic. I would have been a member who has taken their life because they could not stand

the circumstances they're in.

In my case, I have a good spouse who was with me here last time. I have a very supportive spouse. I have a supportive family. But not everyone is that fortunate who finds themselves in these circumstances.

But I can tell you what I have gone through right now, I'm glad it's me. I'm glad it's me. I would hate for this to be a young person with kids with a mortgage, with additional pressures that I do not have. I can tell you emphatically they would not have made it to this point.

CO-CHAIR NATHAN: Well, I appreciate your frustration, and I recognize that sometimes the uncertainty of a decision is worse than the decision itself because it is hard to get on with your life when you're in, using your terminology, "limbo".

You're being followed where for your TDRL? Where do you go back for your periodic examinations?

MR. RICHARDSON: I do not know. I guess the questions -- I've been referred to civilian healthcare providers.

CO-CHAIR NATHAN: Okay.

MR. RICHARDSON: National Spine and Pain Center is one of them. And then, as I mentioned, Dr. Steven Hughes from Commonwealth Orthopedics is the other doctor --

CO-CHAIR NATHAN: What facility processed you for your TDRL? What military facility processed you for your TDRL?

MR. RICHARDSON: This was in Norfolk. This was at MEDHOLD East, I guess.

CO-CHAIR NATHAN: Were you seen by providers at Portsmouth Medical Center?

MR. RICHARDSON: Yes. Yes, Admiral.

CO-CHAIR NATHAN: Okay. All right. Well, I'm going to pull the string on it because you were in the Navy, right?

MR. RICHARDSON: Yes.

CO-CHAIR NATHAN: Okay.

MR. RICHARDSON: Still.

CO-CHAIR NATHAN: So, I'm going to pull the string on it, and I'm going to see where your TDRL status is. I'm going to see what the last results of your periodic examination was. And then, if it's warranted and it's cricket, we'll see if we can expedite decision on -- if your MEB/PEB warrants it, we'll try to get you into a definitive status of retirement.

MR. RICHARDSON: Yes, sir.

CO-CHAIR NATHAN: Now that system is that system, and that system can vary depending on the degree of your injury and what the findings are and how the VA rates it. You can have a compensatory rating from zero percent to 100 percent.

But I think what you're saying is, "Please let me get on with my life. The TDRL status has allowed me to either return to training and be on active duty and pursue my

military career, nor has it allowed me to really put a stake in the ground in the civilian sector and get on with a job and do other things. And I'm still having pain and issues, and they have me one foot in the military and one foot out of the military. And I'm still in pain, and I can't really function well. And I need to be an ultimate dispensation of my disability status."

MR. RICHARDSON: Yes.

CO-CHAIR NATHAN: Okay.

MR. RICHARDSON: Yes.

CO-CHAIR NATHAN: Got it. Thank you.

CO-CHAIR CROCKETT-JONES: Now we welcome Ms. Darcy Hotchkiss, a veteran and practitioner of bioenergy therapy for those diagnosed with PTSD, to provide her statement to the Task Force. Members can find Ms. Hotchkiss' information behind Mr. Parker's information in tab H.

MS. HOTCHKISS: Good morning.

I'm Darcy Hotchkiss. I'm an Army veteran, a GS-14 cyber-security analyst, and an accidental practitioner of the Domancic Method of bioenergy therapy.

In my free time, I provide donation-based healing events, group events, for civilians, military, and veterans with a diagnosis of PTSD and more. A common theme I am hearing from veterans coming to our clinics is that they've gone through the traditional treatments with the medicine and the counseling and the talk therapy, and they don't want to continue to relive the pain over and over again that they do in the talk therapy.

One veteran said he feels worse after attending the counseling, and another veteran said that the medication makes him feel disconnected, groggy, and destroys his ability to be intimate with his wife.

So, what we're seeing going really well with this therapy is we're experiencing

and seeing positive effects of bioenergy therapy in a group environment. In some cases we are seeing the PTSD symptoms completely managed to where they don't need medication. In a lot of the other instances, we are actually seeing the symptoms of PTSD completely reversed.

I'm in no way suggesting that bioenergy therapy is a replacement for conventional medicine. We don't see ourselves in competition with medicine because what we're doing is not medicine.

As an alternative to what is being done and might not be completely working with veterans, we would like to see bioenergy therapy offered on a larger scale in a group environment to those who would like to try something different. We see ourselves alongside medicine or in collaboration with medicine, as an alternative to the traditional methods that do not resonate with everyone.

We're getting amazing results with

bioenergy therapy, and we believe the proof is in the results. Because why else would you do it if you don't get results?

We think everyone should have access to this method. And that's why I spend all my time doing it.

If there are no questions, that concludes --

CO-CHAIR NATHAN: So, there is no question that alternative complementary medicine or therapy has become much more integrated into the holistic approach to emotional health, especially that of Post Traumatic Stress, which ranges from the chiropractic to the acupuncture, to the biofeedback, to the art therapy, to massage, to a variety of things. We are now starting to see more and more types of therapies that are designed based on imagery, based on supplanting the thoughts, the traumatic thoughts of PTS.

If you could -- and this is maybe

challenging -- but if you could, in a nutshell, what is the center of gravity of the bioenergy therapy? How does it differ from talk therapy? How does it differ from therapy of imagery replacement?

MS. HOTCHKISS: Bioenergy therapy, the way that it is done I think is something that sets it apart from all the other alternative therapies, in that it is a little bit more palatable. It is done in a room similar to this in chairs similar to this. People are sitting or standing. They get individual sessions. We can do 60 to 100 people at a time in the group events. And you're sitting or you're standing. It takes about 15 minutes.

There are a few specific movements that we work in the bioenergy field, the energy field. If that term is not known to you, the Chinese call it Chi; the Japanese call it Qi; the Indians call it Prana. It is a bioplasmic energy field.

So, we work in that bioplasmic energy field. What that does is it optimizes the immune system, and it starts reversing major diseases.

We have done Life projects in LA, where we have done with Parkinson's and MS. We have that documented. And there is a documentary done called "Think About It," where we have documented all of this. It has been 40 years going, Eastern Europe and just now kind of getting to the U.S.

CO-CHAIR NATHAN: And there's a long history of East versus West, you know, as far as adoption of medical practice and those sorts of things. Do you know of any -- this is not an endorsement for or against it -- but do you know of any major marquis institutions of care that have adopted it as part of their pain therapy and/or healing therapy, in the Mayo or Hopkins or Stanford or Duke?

MS. HOTCHKISS: Not yet, sir. It's fairly new to the United States. There's

only six of us that are actually at my level that we can actually host groups and things like that.

I would love to get that. I would love to get this in front of anybody who would give me 200 of your worst. You just give me 200 of your worst and I'll show you 200 miracles.

And I stand behind that. I have a team of therapists that also stand behind that. We have videoed it. We've documented it.

And we get amazing results. I think results are why we get up every day and do what we do. We want to see results.

I'm an engineer. I didn't mean to do this. This is not where I saw my career path going.

CO-CHAIR NATHAN: Yes.

MS. HOTCHKISS: But I can't not tell you about it because it is something so amazing that it shouldn't be kept a secret.

CO-CHAIR NATHAN: Well, thank you. Do you have questions?

(No response.)

Thank you for your passion and for your presence here today.

MS. HOTCHKISS: Thank you for the opportunity.

DIRECTOR DAILEY: Ladies and gentlemen, in addition to the oral statements, there are two written statements in tab H.

The first statement is from Mr. Bertram Jenkins, a Naval Reservist who provides a case demonstrating the hardships of trying to appeal a discharge through the PDBR.

The second statement is from Mr. Paul Rieker regarding alternative therapy methods for those diagnosed with TBI.

CO-CHAIR CROCKETT-JONES: And now, from the Population Health Medical Management and Patient-Centered Medical Home Division under TRICARE Management Activity, we welcome Ms. Ginnean Quisenberry, the Division

Director, and Ms. Derenda Lovelace, the Division's Case Management Nurse Consultant. Ms. Quisenberry and Ms. Lovelace will update us on medical care case management information provided in 2013 and on the status of the publication and implementation of DODI 6025.20. Please refer to tab I for their information.

Glad to see you back. Ms. Quisenberry, I'm going to turn it over to you.

MS. QUISENBERRY: Thank you.

Good morning, Ms. Dailey and Members of the Recovering Warrior Task Force. We appreciate the opportunity to be able to come back and give you an update on the publication and ultimate rollout of our Medical Management Department of Defense Instruction.

So, I am going to manage two things. So, please bear with me.

So, the primary questions that I was asked to address today involve the

service-level publication as a result of the Department of Defense Instruction publication that recently came out in the April timeframe. In addition, the impact of the delivery of those medical care case managers and how this is being rolled out within the care management teams; our coordination and participation with the Interagency Complex Care Collaboration that is currently going on with DoD/VA members, as well as the results of our Wounded, Ill, and Injured Survey that we had the opportunity to get some questions in and get feedback from those injured service members, family members, and such. So, we had an idea of if what we were doing was the correct approach and where we were going and where we needed to right the ship, so to speak.

So, in starting out, I think it is important to note, with the implementation of our Department of Defense Instruction, that no longer are our Services really looking at

medical management in its purest sense of what it entails. We have become and matured a little more, and are starting to look at across the Services with the implementation of their policy, what it means to be a care management team, as opposed to just simply medical management and the benefits of what each program under medical management, that being disease case utilization with the linchpin of referral management, means.

We are now going along with the Services. We are getting much more mature in our approach and a holistic, patient-centered type of approach. That is being implemented within the policies that we see across the Services, of which we can look at:

Starting out with the Navy medicine, they currently have their BUMED posted policy and, again, looking at that holistic patient-centered care management type of approach, and what that means for each member of that care team and how they interact

not only within that primary care setting, but those supporting settings that might be beyond that primary care setting, and how that collaboration and discussion is going on between those teams.

Air Force is taking on an approach of rescinding, actually, their clinical medical management program and rolling that into the population health, making it a population health medical management type of umbrella, which is, then, considering another arm of medical management of our chronic care conditions, because they are certainly going to impact our wounded, ill, and injured and the healing and what they're going through with their injuries. So, they are rolling in both into one policy and recognizing the care management team patient-centered approach across the medical management umbrella.

Also looking at Army, they are putting out and their new OP Order came out where they are looking top-to-bottom and

they're making sure that they're looking exactly how they're implementing medical management, how they're looking at the approach and making sure they're reducing the variance of what each team member is doing, and how they're applying those medical management applications.

So, top-to-bottom, it is really looking for all Services as we get more mature with a care management type of team approach as opposed to a simple what are we doing in utilization management; what are we doing in disease management. How are they interacting with each other, and how are we applying that where we're talking to those members of the team that need to collaborate and be able to approach the care needed for those members?

Are there any questions with that?

(No response.)

So, I wanted to give you some examples, now that we have an idea of how the care management teams are coming into play and

give you some examples of the impact of that.

One thing that we have started across the military health system -- and I understand you had a presentation on that -- was our Patient-Centered Medical Homes. So, how are our medical management teams becoming part of this?

Well, as the Patient-Centered Medical Home team concept has matured, they are now rolling in not only our primary care settings, but they are rolling in those case managers. They're rolling in those care management teams as part of that patient-centered team.

They are looking at care coordination through a real-time approach. Therefore, if our case managers are embedded in those primary care team settings, where they're coming in for their appointments, they have the opportunity with those case managers right there to touch them real time, to be able to follow up with them in phone

conversations or be looking at what their needs are before they come in, and getting with that primary care physician, making those appointments much more robust for that member coming in to be able to address their needs.

In addition, they are looking at the secure messaging, where we are able to reach out and talk with our members beyond just those primary care setting walls. So, that is now being, the secure messaging tool is being rolled out, and in some cases the case managers are having the opportunity to roll that out and be working right with those members.

So, the priority in doing so also, then, helps our patient-centered approach because they are NCQA-certified homes, and they are being able to recognize the NCQA requirement certification, which is No. 3 for them, that talks about that care coordination and the care management, allowing our medical homes to become much more mature, recognizing

the support that they provide and allowing that care entire type of approach.

In addition, we are rolling out and looking at a Tri-Service Work Flow Form. In the past, much like medical management, where we approached the concept of it, we are now expanding that concept and looking at where is the documentation.

I know something that you have heard a lot about is, where do we document; how do we find that information for our members that need that care? Well, we are working on and trying to roll out a brand-new Tri-Service Work Flow Form, which will help, much like a care plan, helps identify those elements of needs for those members in one standardized fashion in which all of our Services, recognizing the care management approach, holistic care, have come together and built and identified what elements of care need to be involved in those.

Right now, we are working on the

rollout of them. It has been through a beta test. It is moving into a pilot and rollout, where inclusive of that will be the education and training that will include all of our case managers with our Service partners at the table with us.

MEMBER KEANE: I have a quick question.

MS. QUISENBERRY: Yes.

MEMBER KEANE: Ma'am, is that going to replace the CRP?

MS. QUISENBERRY: I'm sorry?

MEMBER KEANE: Is that plan that you mentioned, is that going to replace the CRP?

MS. QUISENBERRY: What is the CRB? I'm sorry.

MEMBER KEANE: CRP.

MS. QUISENBERRY: CRP? No, no. No, this is where we're in our primary care settings. And so, when we have the opportunity to address those elements, this

will not be replacing the entire plan, recovery care plan.

This is when, if you are my provider, I'm coming in, and that case manager embedded in there, I'll be able to have a documentation site where I will be able to put your needs or you will be able to identify my needs. So, that care management team would be able to see that.

Elements of that, though, are included within the recovering plan because they are the same type of element type of approach. This is helping our Patient-Centered Medical Home in looking at the care coordination embedded case management needs, and they are similar in nature. But, when we are looking at the recovery care plan and where that will be housed, and possibly moving to one type of system where that could be, that is not being replaced, but it has certain elements that support that.

MEMBER KEANE: It does seem like a

duplication of effort. And if we are trying to get the Services to all get online with the CRP, your creation of a new thing, which maybe only you have access to, seems like a duplication of effort in a stovepipe.

MS. QUISENBERRY: It actually allows the opportunity for those primary care providers, though, to be able to have that in that medical record for them. So, that team and that provider would be able to see that as one of his tabs on the treatment within the medical record specifically, that that case manager embedded in that primary care setting.

So, this is not so much looking at the care plan, you know, across the treatment settings that we are looking to, but more of in that primary care setting how that team would address those needs, allowing the primary care provider to have visibility on that. He would be able to click over and identify, hey, we have a plan, and what do we need to be working on. If it is chronic care

conditioning, what meds; how are the wounds healing, things like that.

So, our primary care providers are not having to go to a separate place, but are remaining with the string of having all the documented or the care needs in one place for that primary care team and provider.

MEMBER MALEBRANCHE: Ms. Quisenberry, in light of -- I know you're working with the Interagency Care Coordination piece, as is Derenda, closely in doing this. When you are doing this, and knowing what's coming aboard, was this done in concert with knowing how it's going to roll into the IC2 or IC3 effort?

MS. QUISENBERRY: It was done in recognizing that the elements would be the same and trying to drive the care at the point of care for our providers. So, it's not something that would be not visible for our providers.

MEMBER MALEBRANCHE: So, with the

IC3 coming onboard and for the more complex patients and those that are not perhaps, this will be still part of the plan and the care and the documentation because it will be part of the medical home, if you will?

MS. QUISENBERRY: Yes, and those direct-care members, those members in the direct-care system would be able to readily see this form.

MEMBER MALEBRANCHE: All see it?

MS. QUISENBERRY: And it would be a standardized type of approach, instead of us trying to find pieces and parts of documentation in records where you literally have to go through each chart to be able to find. It would be a standardized format that the Services have come together, that we will use and recognize.

MEMBER MALEBRANCHE: Then, I guess I am still a little bit, with what Colonel Keane was saying, with the comprehensive plan, where does that fit as part of this? It is

part of this?

MS. QUISENBERRY: It can be part of it. It will be part of the elements of it. But, as we are developing that comprehensive plan, we needed something to be able to be now and supporting our Patient-Centered Medical Home approach in having a holistic way to be able to treat these members.

And it will be elements of it that can be part of that plan, but it will be something that our providers would be able to go to and readily see the needs. As opposed to the Recovering Coordinator Plan, it is going to have, when we are looking at the time that our providers have with our patients, trying to go to a separate place might be difficult for that primary care provider.

CO-CHAIR CROCKETT-JONES: So, this is basically only a medical documentation, and it can be included into the larger recovery plan?

MS. QUISENBERRY: Right. When you

look at the elements of it, they are similar, but it helps identify the primary care provider's ability to help in what needs. If we have, say, for instance, the need for some type of durable medical equipment or some type of supporting services, such as occupational physical therapy, they would be able to readily identify and see that at the point of care, as opposed to going to a separate place. But the elements within it are similar to care plans that would be able to be part of the Recovering Coordination Plan.

We needed to have something where we did a standardized approach within the documentation for our providers, much like the Patient-Centered Medical Home has their CORE form.

MEMBER REHBEIN: So, if I'm understanding correctly, it sounds to me like the same information might be resident in two different places. How do you go about coordinating those two different places to

make sure that it really is the same information?

MS. QUISENBERRY: We would need to be making sure that we're working with that ongoing development of that overarching plan and making sure that we're fitting in with that.

MEMBER MALEBRANCHE: So, I guess the other piece -- and again, Derenda has, I know, worked on this, as you have, Ginnean. But for this DODI that is out there, when the IC3 piece comes and this overarching piece comes, this will, then, line up and be in concert with the IC3, so that we don't have anything in competition with.

But I guess the concern here -- and I think I'm kind of hearing that -- is that there's potential for duplication of some things, but I guess that kind of remains to be seen until we get the overarching guidance out there.

MS. QUISENBERRY: Yes, and what I

think you need to remember is, also, it's driving to the point of care, for our primary care providers to be able to see it and act on it with those embedded care managers, as opposed to where the recovering overarching plan in that system will be in a separate place, when we are having patients coming in and those providers having the ability to see that, readily see it and act on the needs then.

What is in that, certainly, will help drive to the point of care where our providers are, so we can get that care coordination much quicker and get the identified needs for our patients. Get it ordered, get it set up, making contact, getting those referrals, whatever is needed at the point of care.

CO-CHAIR CROCKETT-JONES: I guess my question is, would, then, the lead case manager have access to this and be able to import it to the larger CRP? I mean, that

would make sense to me.

MS. QUISENBERRY: This would be standardized --

CO-CHAIR CROCKETT-JONES: Is that the plan?

MS. QUISENBERRY: This would be standardized across in the direct-care system. What we need to do is make sure that the same type of information, as it is developed for this lead coordinator and final plans are in place, and how that's going to look like and where that's going to be housed, will be similar in nature. But that will, again, be at a separate place that our primary care providers doing the care, needing to make the orders, will not have to go to a separate place. It will be encompassed in the home where they are enrolled and receiving care. So, all members of the team will be able to see that.

DIRECTOR DAILEY: And one more time for me, please. This is going to be in

AHLTA, is that correct?

MS. QUISENBERRY: Right.

DIRECTOR DAILEY: All right. And, currently, across the Services there is nothing that standardizes delivery of these elements that you're going to identify? Nothing standardizes its delivery to a Marine, to a Navy sailor, to an Army Service member, to an Air Force --

MS. QUISENBERRY: Who are enrolled --

DIRECTOR DAILEY: Who are enrolled.

MS. QUISENBERRY: -- within that direct-care system to a patient-centered home, where our case managers now will be embedded within.

DIRECTOR DAILEY: Okay.

MS. QUISENBERRY: So, we have come together to try to resolve.

DIRECTOR DAILEY: Okay.

MS. QUISENBERRY: Because, right

now, until we have these overarching plans and guidance in place, we have this documentation in different parts of the chart.

DIRECTOR DAILEY: Okay. Just short soundbites here. This is going to standardize the common elements for taking care of Service members enrolled with case managers across all the Services? They are going to be looking at the same standard elements for a Marine under case management, an Army/sailor under case management, an Air Force Service member under case management? The nurse case managers will be looking at the same element across all te Services?

MS. QUISENBERRY: It's the same form built by all the Services together.

DIRECTOR DAILEY: In AHLTA? In the medical piece? So, right now, that's not how it's managed. A nurse case manager in the Marines, a nurse case manager in the Navy, Air Force may be including in the AHLTA case management different elements. Okay.

So, now CRP currently, ladies and gentlemen, is a non-medical plan, all right? So, you really don't have any -- you are not going in a direction where the non-medical piece is going to be included in AHLTA, is that correct, in your overall work?

MS. QUISENBERRY: It will not, but it has elements such as the financial support, you know, that somebody may need or something like that. Just asking the question in the basic care plan, but --

DIRECTOR DAILEY: Okay. Wait a minute. Wait a minute. Wait a minute.

So, the answer to my question is, yes, this element, the gathering of these elements and standardizing them across case management --

MS. QUISENBERRY: Yes.

DIRECTOR DAILEY: -- across the Services is going to include some non-medical information in AHLTA?

MS. QUISENBERRY: It will such as

-- yes.

DIRECTOR DAILEY: Okay. Good. Yes. So, it will include some non-medical elements in AHLTA for the medical guys who are now going to be able to see some non-medical elements in AHLTA? So, some of it is going to be imported into a medical setting, into the medical home setting?

MS. QUISENBERRY: Yes, yes.

DIRECTOR DAILEY: Okay. And that's what this is going to do, assist in doing? All right.

Now is it going to be, is the VA setting up a similar system for their medical home?

(No audible response.)

Okay. Good answer.

MS. QUISENBERRY: I would have to make sure. I mean, I would have to go with our medical home team, but, currently, the efforts are underway within our direct-care system.

DIRECTOR DAILEY: Okay.

MS. QUISENBERRY: Certainly, our medical home team speaks and works with our VA partners, but they have rolled out with our NCQA-required Patient-Centered Medical Home approach within the direct-care system.

DIRECTOR DAILEY: Okay. So, last year when we were talking with the Navy nurse case managers out at Camp Pendleton and they were saying they have to print out a CRP for me, I don't know what's going on in the CRP.

This, having it embedded at the point care -- she keeps using all this language, point of care, blah, blah, blah -- having it in AHLTA, so that the nurse case manager can look at it solves that problem or helps solve that problem? Is that a correct assumption, a correct visual for nurse case managers?

MEMBER KEANE: Unless you're in Iowa, because Iowa they don't have enough access to AHLTA, right?

DIRECTOR DAILEY: All nurse case managers have access to AHLTA.

CO-CHAIR CROCKETT-JONES: Just so I get a picture of this, who qualifies for Patient-Centered Medical Home? What puts you in that system?

MS. QUISENBERRY: Okay. So, for myself, I'm a spouse of an active-duty Service member. So, right now, I am enrolled in the direct-care system to a site that has a Patient-Centered Medical Home. So, I am enrolled into -- if they have a Patient-Centered Medical Home which they are rolling out, you know, they continue to roll those out, then I would have that.

And so, for example, if I had a chronic condition, I now have the ability to speak directly. I don't even have to go -- I have the secure messaging ability to speak to you as my provider and say, if I have asthma and it's severe, I would be able to say, "Hey, listen, I'm starting to have some type of

wheezing. I feel like I'm possibly getting worse. I'm escalating my -- I'm having a chronic, you know, an acute episode," I would have the ability to speak with you. And then, you may be able to put me with my case manager and help me address that and get into an appointment before I wind up in an urgent or emergent care setting that is not going to give me the continuity that I get from my primary care provider. Therefore, I am reducing episodic care and improving the ability for my primary care provider to be able to keep me in a stable way moving forward.

Simply put, Patient-Centered Medical Homes are rolling out. They continue to roll out. They continue to be mature. I have the ability to enroll that into one, if it's available and if they have room, the availability, if the MTF is not full, capacity, basically.

CO-CHAIR CROCKETT-JONES: So,

basically, this would mean that before folks have -- before a Service member becomes wounded or injured, if they were already enrolled in a Patient-Centered Medical Home, this form would, then, be generated, so that --

MS. QUISENBERRY: It can apply not only to a wounded, ill --

CO-CHAIR CROCKETT-JONES: So, then, they can be pushed into -- okay, I get it.

MS. QUISENBERRY: Yes.

CO-CHAIR CROCKETT-JONES: I'm getting a clearer picture.

MS. QUISENBERRY: This can apply to anybody. So, it expands beyond our wounded, ill, and injured. This is a form that will help address the care of our beneficiary population as a whole enrolled to our direct-care system. So, it has value in two ways.

Any other questions? Do you have

any other?

CO-CHAIR NATHAN: Just a comment about it. So, this is, ideally, the new panacea for trying to reduce cost and increase health in the military health system. It is designed, really the tenets of the Patient-Centered Medical Home is to be built upon one leveraging technology, which is leveraging communication to the patient through asynchronous web communication, like RelayHealth, email, telephone, smoke signal, carrier pigeon, whatever?

Older patients prefer telephone. Younger patients prefer an iPhone app that they can use that is web-based.

The other tenet of it is leveraging preventative health. It is designed to track through electronic databases much more aggressively healthcare screening, colonoscopy, mammography, cholesterol, diabetes, asthma, smoking cessation, all those things.

And then, what it is designed to do, ideally -- and this is what you are bringing into it -- is, basically, help manage the care of the patient, case management, clinical case management, so that things don't fall through the cracks.

So, old system, you go to see your family practice doctor, your pediatrician, your internist, and they tell you, "You need to see the urologist because you have something going on with your urinary system. Go get an appointment." And you disappear, and whether you get it or not is up to you. Whether we know you have it or not is up to you.

New system, there is a care manager/case manager in that primary center medical home who, then, facilitates that appointment for you, checks, has a database. If you haven't made the appointment, then we find out. And then, we call you back and say, "Go get the appointment or we'll make it for

you."

The other major thing -- I can't remember if you discussed it or not -- about Patient-Centered Medical Home is the other tenet is it embeds primary care emotional health within the patient's medical.

The old system, you come to your primary care doctor and you start weeping or crying during the blood pressure visit and they say, "Oh, my goodness, what's wrong with you?"

"I'm just not doing well. I'm losing sleep. I have issues at home with my children" or my PTS or my spouse, or whatever.

"Oh, my goodness, let me put in a consult for you to go see one of our mental health providers, and give me a call if you have trouble making that appointment or can't get one."

And you don't hear anything from the patient. So, you assume things must be okay.

When Patient-Centered Medical Home is working very well -- and this is key to the Recovering Warriors -- when it's working well and it's staffed correctly, you, then, are sent from that primary care doctor or provider, nurse practitioner, PA, down the hall to the primary care mental health provider, a psychologist and/or psychiatrist and/or social worker who sees you then. It may be for five minutes to just get you in the door and say, "How are you doing? Let me take a quick look at you, make sure you're okay. I'm going to see you back in three days." But it's all continuity.

And then, the last thing is it's based on the pod concept. It is based on the fact that you are enrolled to a pod of people, usually which is a physician, an extender like a PA or nurse practitioner, and then, medics or corpsmen. And when one of them is gone, somebody else knows your case.

Then, the last thing -- and this

is the thing I like about it -- is that, when it is working correctly, and this, again, is key for Recovering Warriors -- you are able to reach somebody at anytime of the day or night who works in that Patient-Centered Medical Home pod for which you are assigned to.

Wouldn't you agree, most of you who have used the military health system, if you called up at 10 o'clock at night to talk to somebody who participates in your care normally and said, "I need to get a hold of them because this medicine isn't working," and they put you through to somebody who knew your care, you would probably have to get defibrillated, right? You would grab your heart and fall over.

What a novel concept now that, instead of getting a phone call that says, "If this is an emergency, hang up and call 911; otherwise, clinic hours are at 0800 in the morning." Okay? What a novel concept that the phone is actually answered by somebody who

listens to your concerns and says, "You know, your concerns are not serious. I'll take a note and pass it to your team in the morning" or "Let me put you through to the person who's got the duty for your team tonight and let them talk to you. And they can either advise you to come into the emergency room and/or they'll be able to see you tomorrow and know everything that's going on about you," which is how patients who have good coverage and good practices in the suburban and outside system get care.

So, those are all the things about it, and it's working. Patient satisfaction is going up. Patient cost is going down. Preventative medication and preventative health is going up. And the trick is to hire a stable critical mass workflow, including case managers, that can be embedded there.

One last sea story. The Marines went into this kicking and screaming. The Marines are wedded to the -- no offense, but,

you know, God love the Marines -- they are wedded to their Battalion Aid Stations with their mount-out boxes, their curtains. If the Lord wanted us to have running water in our clinics, we would have been born that way.

And we said, "Can you just try medical home?"

And they said, "Well, that involves us giving the care over to the military treatment facility vis our own Battalion Aid Station with our own battalion doctor."

"That's correct. But we think we can take better care of your Marines."

And the Marines, who have tremendous unit integrity, didn't want to do that. Now, a year into it, they would do nothing else. All they want is the medical home concept. Because Marines who before you would give the consult to and you would say, "Go see the dermatologist," and the Marine would say, "Yes, sir, this Marine will go see

the dermatologist." And a year later, you would go, "How did that go for you?" "How did what go for me, sir?"

So, now the case manager facilitates that Marine getting into the dermatologist and calls the gunnery sergeant and says, "Your Marine never made the appointment." Better care. Better health. Better readiness.

So, I just wanted to give you an overview of why we're adopting across the military medical home. And I would like to say we thought of it, but it really started with Geisinger and Intermountain Health and some other premiere marquis managed care systems. But we're doing it well.

And the last thing is that it requires -- and here's the good news -- we don't have a great one, but we have a decent one, an electronic medical record, that four-letter word or that five-letter word, AHLTA. But at least it supports a medical home.

MEMBER PHILLIPS: Just a supportive comment. We do learn. As you mentioned, back in the eighties, Kaiser did a huge study where they told their subscribers, "If you think you have an emergency, just call this 1-800 number, and they're able to speak to a healthcare provider."

Of the 100 percent of the people that thought they had a real emergency, about 70 percent didn't have an emergency at all. They were just given an appointment. About 10 or 15 percent had an urgent problem that could be delayed for 24-48 hours. And less than 15 percent had a true emergency.

So, it saved anguish, time, money, and effort. So, this is a great step forward.

MS. QUISENBERRY: That is correct. That is correct. And we speak with our Kaiser folks, especially I speak with the representative for their Care Management Institute. I want to get an idea because that's exactly what they implemented to

address that type of episodic or to reduce that episodic care and maintain the continuity within their primary teams.

And it has worked very well for them, as opposed to the HMO model that we all heard some years ago, that you go to that provider or you have the costs associated with not going to that provider. We have all grown and realized the care management approach that they adopted in Kaiser, that we adopt in our Patient-Centered Medical Homes, and where it is a holistic type of need.

I think what would have helped is if I had identified at the outset for our Tri-Service Workflow AIM Form that it is for all of our beneficiaries, with our wounded warriors who come into those care management teams benefitting from that.

MEMBER PHILLIPS: And they had one piece of advanced technology. It was called a dial-up telephone.

(Laughter.)

MS. QUISENBERRY: Yes.

DIRECTOR DAILEY: So, we are intrigued by this standardization of case management, primary elements, tracking data. Can you get us a copy of what's going to be in this bullet, the new Case Management Tri-Service Workflow? Is there --

MS. QUISENBERRY: We should. That is going through the piloting right now.

DIRECTOR DAILEY: Correct.

MS. QUISENBERRY: So, it is morphing and changing because we want our members to be able to use that. You know, they have a core form that addresses what was just discussed, all the elements, outside case management. And we can get that to you. But, knowing that it can still be changing --

DIRECTOR DAILEY: Yes.

MS. QUISENBERRY: -- I think is an important point to make, as our case managers are using it.

DIRECTOR DAILEY: Agreed. Agreed.

Can you get us a copy of what is being piloted?

MS. QUISENBERRY: Uh-hum.

DIRECTOR DAILEY: Okay. That would be great. Thank you.

MS. QUISENBERRY: The next one, we're looking at the application or the impact of our medical care case managers with the implementation of the Medical Management DODI. We are going back to and identifying and recognizing the importance of our skill set development, and in doing so, moving from the current type of training that we have available to including now both our clinical and non-clinical sets as well as our VA partners.

And I would like to thank Ms. Malebranche and her team. As a matter of fact, they have been working with us and provided us a really wonderful updated VA care set that we are working right now to finalize and get put out there.

So, recognizing the skill set development, the ongoing changes and benefits that we all have through our Title 10 entitlements, the ongoing changes with the VA, the Affordable Care Act where a lot of questions come in and how does that impact, we are trying to make sure that, as we look at our education and training and our skill set development of our case managers, that this is moving as all the other elements around that are moving with them.

Also, what has been identified with the skill set development is working with our service partners in making sure we have a concerted effort for a quarterly training emphasis, taking the model known by Patricia Benner of our novice-to-expert approach, where we have our novice case managers that are moving into this to our more advanced. How do we identify those?

We have the training available. We are working with what we just talked about.

But how are we making sure that we are capturing and getting feedback from our case managers and our non-clinical case managers in their understanding of it and catching those new members and making sure that they're able to access it, get it, if they have any questions.

Because we have new members that move into it that might not know what a case management concept is or how to apply that. So, what we have done is our Services have identified we're going to do a quarterly training emphasis where we take our Department of Defense required training and just look at a few at a time over quarters where our Services have identified they will work specifically with their case managers, making sure that they are going to be able to access, get the training. Is there anything missing? Constant feedback allows us to continually update our courses, enhancing our skill set development of those case managers.

And finally, recognizing the impact with our interagency transitions. Previous Department of Defense Instruction, we worked with our Service members; we worked within the Department of Defense. That is how we developed that.

Currently, recognizing the need for the interagency and how we reach out to our partners, we have included in our Department of Defense Instruction the elements of those VA care management teams, invited them to the table. And they were able to help develop that Department of Defense Instruction, and we have the ongoing impact of their input at our meetings where they are invited to the table with our TRICARE Regional Office partners, our Service partners, and our VA partners. That is in place. It is an ongoing feedback loop, as one impact for us to continually involve, learn, and identify and act on barriers as quickly as possible.

Caseloads, there has not been any

change to designate a certain caseload for case manager because, again, as we have discussed, those remain dynamic, in line with national standards that we have, going back, again, to the guiding standard of a case manager for our CMSA, our Case Management Society of America, who, again, worked with the Social Workers' National Program Office in recognizing there has been no determined caseload per case manager. So, those remain dynamic, allow the Services to identify with whom they have, applying their case management as to the caseload per case manager, but nothing in that DODI is identified as one number.

Next is the identification that we have talked a little bit about with our Interagency Complex Care Coordination Partners. My office has had the opportunity to work in support with two of those Work Groups, one being the Policy and Oversight, in mainly a supportive role to help make sure

that's getting through concurrence and to be able to supply any information needed to our HA leadership.

This Policy and Oversight is being put in place as an overarching guide for our DoD and VA partners as we move toward one model of a care coordination type of concept.

The Community of Practice Work Group, where we have had the opportunity to be a little more involved and engaged, because it is really more with the application of the benefits and how we are engaging in the care coordination process, where we have taken part in identifying the support, working again -- we have been asked if we would be able to identify some type of web-based interagency type of training support.

We're trying to identify how we do that, especially in a very cost-constrained environment, when you're asking one department to be able to supply that training platform for both agencies. So, we're working on that.

Our VA partners at the national level are looking at possibly how they can support that through educational units that case managers and our social workers on both sides need for our individual licensure.

One thing that I have been asked, and as I was working with the development of these slides with our partners, is, also, this is working towards the Lead Coordinator concept role development within these Work Groups. And one thing, if nobody has mentioned it before, I really want to focus on the fact that this Lead Coordinator is not a new position. This is not a new FTE that is being added, but using the FTEs or the case managers that are in place and identifying a lead representative and how that will be developed and identified and understood between both DoD and VA.

Questions?

(No response.)

So, again, right now, we have this

MOU, our Memorandum of Understanding, that is moving through right now for this overarching guidance through our formal concurrence process that will go through all the Services and the VA. As we receive that input, this group, Policy and Oversight Group, will address and modify and change, similar like we did with our Department of Defense Instruction.

And again, the elements that we're looking at for this comprehensive plan is to continue to identify the role of this Lead Coordinator, the role of the care coordination process, and how this is going to work between both agencies to make sure that we're applying similar concepts through policy development, through rollout of the care coordination across the agencies, a guiding principle, so to speak, where we can come together.

And finally, we had the opportunity -- as you all are aware, trying to start a survey is costly in and of itself --

so, we had the opportunity when I was here before to identify that we were able to add questions into our existing Wounded, Ill, and Injured Survey. That survey, again, because of budget concerns and constraints, was finalized in the third quarter of 2013.

We took a look at that, and we proactively identified the questions that were within that survey and identified that within the Lead Coordinator concept, and how they're working and identifying the feedback from their Service members, there were similar questions that were identified. So, we are able to utilize or transition in working with that lead coordinator group to get the feedback from those questions, so we have ongoing feedback as to how we are doing.

Results of the ended Wounded, Ill, and Injured Survey, though, I'm glad to report we are showing that we have an 80-percent satisfaction rate, or approximately eight out of every ten individuals were satisfied. We

are getting good feedback, which aligned well with the last publication of the Recovering Warrior Task Force Annual Report, where we saw the positive feedback coming back with case management.

Two areas that we have found are the continued need for the support of guiding an individual through the care management process or the systems, obtaining medical care, both in the DoD and VA. Also, this will be, going back to that patient-centered concept, having those case managers right there. Perhaps we will be able to identify that a little earlier on and be able to be proactive in that management.

The other is wanting to make sure, again, that skill set development, making sure our case managers are aware of the evolving and changing benefits or any changes with case management approaches within the DoD or VA are understood, that we will be able to address through this ongoing training and education

with our clinical and non-clinical partners.

DIRECTOR DAILEY: So, this was going to be the only report you got out of the telephone survey? Because we talked to Dr. Bannick; the survey has been discontinued.

MS. QUISENBERRY: It has.

DIRECTOR DAILEY: Okay.

MS. QUISENBERRY: And so, what we wanted to do is make sure, to have a trendline, we want to make sure we have at least three quarters to report, to be able to report something stabilized out. And so, what he was able to provide us was those results.

DIRECTOR DAILEY: Okay. So, he actually went back before you implemented the new directive and took all the data from previous data that he had gathered and gave you these results?

MS. QUISENBERRY: Yes.

DIRECTOR DAILEY: Okay. So, the ability to really assess the impact of your DODI will not be evaluated by this survey

material?

MS. QUISENBERRY: No, unfortunately.

DIRECTOR DAILEY: But the case management that existed during the survey period --

MS. QUISENBERRY: Yes.

DIRECTOR DAILEY: -- got a pretty high rating, basically?

MS. QUISENBERRY: Yes.

DIRECTOR DAILEY: Yes. I mean, again, like you noted, case management are the heroes. Nurse case managers are many times the heroes.

Did you do any other parsing or did you ask him to do any other parsing of this case management survey data by Service, age group, rank? Did he parse it out in any other way?

MS. QUISENBERRY: We would have to go back. I don't know if he was able to do that. We only had five questions. We were

embedded in a larger -- because starting a survey --

DIRECTOR DAILEY: Yes.

MS. QUISENBERRY: -- as you know, you have to go through WHS and it is costly.

DIRECTOR DAILEY: Yes. No.

MS. QUISENBERRY: So, we embedded --

DIRECTOR DAILEY: It was very creative. I'm a real firm believer, actually, in this survey over that of the Services. So, I was disappointed when they eliminated it.

MS. QUISENBERRY: Yes.

DIRECTOR DAILEY: I was intrigued when you were going to use it as a way to measure the effectiveness and get feedback from your customers. So, that is why we wanted you to talk to us about that.

MS. QUISENBERRY: Yes.

DIRECTOR DAILEY: So, just a thought to help parse out where your customer and your service base satisfaction and

dissatisfaction might be would be, if he still has the data, which he does, and he can still analyze it, to ask him to go back and look at it by maybe age group --

MS. QUISENBERRY: Okay.

DIRECTOR DAILEY: -- rank, Service. And then, you will be able to customize or look at what does a young E3 need --

MS. QUISENBERRY: Right.

DIRECTOR DAILEY: -- in areas of case management. You know, who was or is delivering services? So, you get my point.

MS. QUISENBERRY: Right.

DIRECTOR DAILEY: Yes, if the data is there, sometimes you get very small sample sizes which might not be helpful to you, but if he has got three quarters, he might have a large enough sample size to help you identify groups and segments that could use tweaking.

MS. QUISENBERRY: And we could certainly bring it into the efforts with the

IC3 and say, you know, "This is what we were able to find to that granularity."

DIRECTOR DAILEY: Yes.

MEMBER EUDY: Ma'am, regarding the Tri-Service Workflow, how is the non-medical information going to be populated, then, into AHLTA? Is that going to be placed in by those non-medical care managers? Is it automatically pulled from those other systems to make sure that -- because a lot of the nurse case managers are already heavily tasked on a lot of non-medical systems already that they have to evaluate. So, how does the data get in there?

MS. QUISENBERRY: The case manager will be populating it. There are questions such as, you know, "What is your family support system?" If you have a job, we want to know how active you are, if you have some type of injury where that will impact your job and being able to do it.

I don't think they're pulling from

any of the systems. It's more of the care plan filled out by the case manager that you'll be able to see when we provide those elements.

CO-CHAIR NATHAN: You have some clinics, like at Walter Reed-Bethesda, and I don't know where else, that are primary care dedicated, organic Wounded Warrior primary care clinics, where the Wounded Warriors get their care specifically in a separate silo of a primary care Wounded Warrior clinic. Are those canvassed as well, those clinics?

MS. QUISENBERRY: We had the WTUs, for example. Those Warrior Transition Unit case managers were part of this development with the elements within that AIM form.

Ms. Lovelace had the -- we set up a Work Group and tried to include.

I am correct in stating that, right?

MS. LOVELACE: That is correct. The Wounded Warrior case managers will be

using the same form. We wanted to make sure it was standardized across all case management. So, all case managers in the direct-care system that are touching a patient will use this form to do their documentation.

MEMBER MALEBRANCHE: I know this survey is over, but do you have any feedback from the Lead Coordinator Pilot? Was there any information back from that, just preliminary? I mean, because this group is looking at Wounded Warriors. Was there anything in that pilot that was exceptionally good or exceptionally bad? Did you have any preliminary from that?

MS. QUISENBERRY: I do not. Because I know that they have had the two pilot sites roll out. So, we can go back and ask how the first one went, because I think they were still in the development of all those tools.

It might just be that point in time in that as well. So, consider that with

the data. But I know they're rolling out to the second.

MEMBER MALEBRANCHE: And the other piece is VA has their own model, if you will, of medical home, which is the Patient-Aligned Care Teams. Is there any or has there been any, when you have been doing this, any work with that group that does the Patient-Aligned Care Teams? I don't think as far advanced as this one is; it's still rolling out. But when a Service member transitions to the VA, do they transition from one home to another?

MS. QUISENBERRY: I don't know if they would transition to the home, because I think they have to go through those OEF/OIF teams for identification and, then, subsequent assignment. I don't know if the VA, based on their category ratings, you know, the 1, 2, 3, 4 --

MEMBER MALEBRANCHE: Uh-hum.

MS. QUISENBERRY: -- I don't know if they're identified from that category

rating and, then, enrolled that way, in a similar fashion as we do regionally or within our MTFs, where you are put right in the home based on your eligibility in DEERS.

I think we would have to look at the category states of the VA versus the --

MEMBER MALEBRANCHE: I know the groupings are different, I mean --

MS. QUISENBERRY: Right.

MEMBER MALEBRANCHE: -- because we don't do the entire family.

MS. QUISENBERRY: Right.

MEMBER MALEBRANCHE: But just something to consider in the future --

MS. QUISENBERRY: Right.

MEMBER MALEBRANCHE: -- as you're looking, because it would seem to make sense to go from one group to another, if you will, as a pod that handles that type of care. Just thoughts.

Thank you.

CO-CHAIR CROCKETT-JONES: Thank

you, Ms. Quisenberry.

MS. QUISENBERRY: Sure.

CO-CHAIR CROCKETT-JONES: Okay. Thank you, Ms. Lovelace.

We will take a brief break and be back in 15 minutes.

(Whereupon, the foregoing matter went off the record at 9:53 a.m. and went back on the record at 10:14 a.m.)

CO-CHAIR CROCKETT-JONES: Okay. We are now going to hear from Mr. Richard Willis, the Director of the Technical Training Academy. Mr. Willis will provide an overview of the Training Academy and provide data describing the Academy's contribution to Wounded Warrior transition. Information can be found under tab J.

And I'm going to turn it over to you. Thank you.

MR. WILLIS: Thank you. Thank you very much.

On behalf of the Wounded Warrior

Project, I want to thank you very much for allowing us to come in and talk to you about the Transition Training Academy.

Before we get started, though, I know that you're familiar with the Wounded Warrior Project to varying degrees, but I want to restate our mission and bold vision for this generation of Wounded Warriors. Our mission is to honor and empower Wounded Warriors, and our vision is to foster the most successful, well-adjusted generation of wounded Service members in our nation's history.

Now a little bit of history about the Transition Training Academy. Back in 2007, Cisco went to the Labor Department with an idea to provide IT familiarity training to warriors at Walter Reed Army Medical Center. This was during the time that the headlines were filled with bad stories about warriors who were sitting around doing nothing and getting in trouble while recuperating.

The Labor Department suggested that a nonprofit organization would be more appropriate to run this program. So, WWP gladly accepted that role.

From there, a very basic familiarity program was created which consisted of a six-week PowerPoint presentation and warriors receiving a laptop computer upon completion. Under the original Cisco plan, warriors were getting minimal exposure, and many of them were trying to sell those computers on eBay. The troubling part of this was that we were not empowering these participants with marketable skills with this model.

Our vision was to create coursework which would allow students to achieve industry-recognized certifications, which would then allow them to be competitive in the IT field of employment. As a result, we created the current model we use today.

The Wounded Warrior Project, the

Transition Training Academy provides innovative information technology training for warriors, Service members, and veterans and their spouses or caregivers. All TTA courses, class material, and exam vouchers are provided free of charge to the warriors.

Let me tell you a little bit about the courses that we offer now. We offer four courses. The first of those courses is called the Introduction to Computer Technology. This is an introductory course. It covers computers and society, hardware, software, computer productivity, networking, the internet, mobile computing, and security. This course is designed to give students the opportunity to look into the IT field to decide if it is something that they're a right fit for. It also gives our instructors the opportunity to see if the student is the right fit for the IT field.

The next course that you see there is our Introduction to Computer Repair course,

and that's our A+ certification course. This course is an active-learning, hands-on course that prepares students to build, install, maintain, and repair computers in small office and home office and corporate environments. Students learn the basics of computer networking design and installation, and the courses also introduce computer security measures through course material and activities that will help them learn to protect computers against internet attacks.

What we found was that a lot of students knew how to get on the internet. They could surf the web a little bit. They could send an email. They could get on Facebook. But they didn't know that they were supposed to have security protocols set up on their computers. They were getting viruses and things like that. So, we created these courses to help them out with that.

The ICR course is mapped to the CompTIA A+ objectives. CompTIA, for those of

you that don't know, is a well-known, highly-regarded, nonprofit organization and a provider of professional certifications in the IT industry. TTA students who demonstrate they are ready to pass the A+ exams are provided free vouchers for the exams. Those exams are the 801 CompTIA A+ Essentials Exam and the CompTIA A+ Practical Application. They do have to pass both of those exams to become A+-certified.

Employers consider the A+ certification an important industry standard for all entry-level computer technicians that could lead to the following professions: help desk technicians, support technicians, bench technicians, technical sales consultants, and network installers.

Which brings me to the next course, which is computer networking or the Net+ Exam. This course is designed for students who want to further their IT careers by acquiring foundational knowledge in

computer networking. The ICN prepares students for CompTIA's Network+ certification. Students will describe terms and technologies associated with the network media topologies, protocols, and standards. Students will demonstrate their ability to design, install, and support, troubleshoot local area and wide area networks.

The next course, then, that we offer is the Computer Security course. And that course is designed for students who want to further their careers by acquiring foundational knowledge in computer security. The ICS course prepares students for the CompTIA Security+ certification.

Now if one of our students is looking for a job in the GS realm, they have to have at a minimum the A+ certification. When they put their applications in, if they can't show that they have the A+ and they don't have that certificate, they're not even going to be considered. The other two are

wonderful to jump on top of the first one, which is the A+, but they must have at a minimum the A+ certification.

Do we have any questions so far on the certifications?

(No response.)

All right. The next slide that we have here is our locations. I know there are some questions going to come up on this one. So, we'll talk about this one a little bit.

You'll see these are our current locations. Down at the bottom of the slide, I have the "coming soon" locations. And you'll see that those "coming soon" and several of those locations up on the top are Regional Offices within WWP. The reason for this is we just got the memo down that several of the WTUs are going to start closing. So, we had to create a model so that we could continue this wonderful work and help these warriors get their certifications that they need.

So, what we decided to do was start moving some into our Regional Offices. So, we're hiring instructors for those Regional Offices to continue the work and teach the classes right out of those Regional Offices.

San Diego Regional Office, we were teaching at Balboa. On most of the installations, classrooms are not a commodity that is very plentiful. So, we lost our classroom at Balboa. We had to move into our San Diego Regional Office. That was actually the very first office that we started teaching the classes out of, and we decided this is probably something that we really need to do. So, we started moving some of them in there.

At most of the locations, we have talked to the command; we have talked to garrison; we've talked to transition coordinators, educational departments, and we have signed MOUs with those locations.

Also, there is a new form that we

just got. That is called the Private Organization Operation Request Form. It is a form that has to be filled out for private organizations that are not part of the DoD to be able to teach on base or on post. We have our Legal Department fill out all the blanks on that. We send it back over to the base legal department. They'll send it back if they need anything else. Otherwise, they'll approve it, and that's how we get our permissions to teach on locations.

We use this for Hunter. We use this for Ft. Stewart, a couple of other locations. Our benefits team actually used it up at Ft. Belvoir and a couple of places up here in the D.C. area to get permission to go on post and on base.

CO-CHAIR CROCKETT-JONES: In the places where you're moving to Regional Offices, how far are they from military facilities, and what how things like transportation for folks who need to get to

you?

MR. WILLIS: Let me address that last part first. In most cases, the warriors are ambulatory and they're able to travel on their own by the time we get them. Every once in a while in the ICT course we will have some that are just coming out of, they are transitioning to where they can actually start traveling a little bit and going on their own. So, we are made part of their appointment process for the week to attend our classes.

After that, we put our office locations in highly-populated areas where warriors have retired and they're staying. So, that is where we put our WWP offices.

If they need transportation, in most cases we can get them transportation. Most of the time, they can already just come themselves to get to the offices. A lot of them are around highly-populated areas or WTUs, but it just means that there's a large population of Wounded Warriors in that area,

and that's why we put the Regional Offices there. Okay?

So, you can take a look at some of those. We're always willing to expand to other areas, but we have had pretty good success so far with those areas.

MEMBER DRACH: Richard, how many of your warriors pass the A, the A1, or whatever? How many have successfully passed it?

MR. WILLIS: Give me a couple of slides and I'll answer that question for you. We're almost there.

All right. So, the next slide here. As of 2013, over 2500 Wounded Warriors, active-duty Service members, wounded veterans, spouses, caregivers have completed the TTA program.

Classes are taught in an instructor-led setting, complemented by web-based exercises, online learning, and peer mentoring. One of the big things that we do,

we have an online learning environment. So, they are getting instructor-led. They also have components on the computer that they have to complete. There is a forum that they have to be a part of, as they are going through the class. So, there's a lot of peer mentoring.

And the really neat thing about our classes is that people that have already graduated from the TTA courses in different locations are coming back in the classroom as peer support for those warriors that are just starting out their training. And I think that's one of the big parts that makes us so successful.

Another big part that makes us very successful in what we do is that all of my instructors came out of my classrooms. They're all Wounded Warriors or spouses of Wounded Warriors, and they are just a perfect fit for this crowd, perfect.

You can't tell them something that they haven't heard or they haven't lived

already. So, that's what makes them such a great fit for it. We have trained them to be the instructors that we want them to be.

And the next part here, the materials developed with those are living with Post Traumatic Stress, what does that mean? We found that warriors who have Post Traumatic Stress/traumatic brain injuries learn better by touching, feeling, and doing. So, we created our courses with that in mind.

Our A+ course, the students actually build a computer in the classroom that they get to keep at the end of the class. That's all free to them. We have warriors in there that have traumatic brain injuries. We have warriors that are missing limbs, different catastrophic injuries. They wall want to build those computers themselves, and they do not want any help. So, they're turning the screwdrivers and doing everything themselves. That part of the course helps them to remember and be able to retain and,

then, recall that material when they need to for those examinations.

Like I said, they get to keep that computer at the end of that course. Another neat thing that the Wounded Warrior Project does, when our computers, our own personal computers from the Wounded Warrior Project, break, they send them to me and I put them in the classrooms with those students that are going through the A+ course. I ask them to troubleshoot computers.

Now you all know, you are sitting at your desk and something goes wrong with your computer. You can call the help desk and they will walk you through: what happened? Were you doing this? Did you put this on there? What happened here?

Well, when they're fixing a computer, they don't have that opportunity. They don't have anybody to ask questions. So, they have to troubleshoot that all by themselves.

What we ask them to do, troubleshoot the computer, see if they can be fixed. We will, then, buy them the parts that need to go in those computers to fix them. Once they're fixed, we catalog them. A Warriors to Work member will call us and say, "Hey, I've got a warrior that needs a computer for this job," or somebody going back to school. Then, we'll send a computer to that warrior who doesn't have the funds to buy their own computer. So, that is another kind of a neat thing that we do in the TTA class for our students.

In 2011, we began using a consolidated record of maintenance system called Salesforce. This system allowed us to track students, their progress through the TTA program. With this program, we can run reports, which helps us to align our students with potential employers and keep track of their certifications.

So, when they get a certification,

they send us the paper back in a PDF. We, then, install it into our Salesforce, and we have that certification and we know how long it's valid for. So, they are valid fore three years now. So, we keep those in our system.

That way, we can always go back to that warrior and say, "Hey, you're coming up. You need to renew yours." Or we have this employer that says, "Hey, I'd like 10 warriors to help me on this contract," or whatever it is. We can go in and we can run a report and find out who has those certifications they're looking for to better track where their certifications are and help us to align them with different jobs.

Now, since 2011, over 2500 warriors, caregivers, spouses have attended and successfully completed the classes. Up to FY14, we had 2622. I didn't bring any numbers prior to that because we didn't have our Salesforce system up and running. So, everything here, we know for a fact that's how

many students we had.

We served 22,185 warriors, active-duty Service members, and wounded veterans; 437 spouses/caregivers went through our courses; 463 Transition Training Academy graduates have become CompTIA-certified in either A+, Net+, and Security+ so far. And that's the record that we have.

What we are doing right now is we're trying to contact prior to FY11 and we're trying to see who we can get to come back to us on the surveys to let us know they have the certifications, a difficult process. People move.

One of the neat things that we do in the Wounded Warrior Project is we have our outreach calls where every single staff member will have a list of alumni to call. We call them throughout the month, and we get updated information on their addresses, phone numbers, and we can ask questions like this to try to update our data.

Two hundred and fifty-one Transition Training Academy graduates have been placed into employment by Warriors to Work teams since FY13. We have a Warriors to Work Specialist that works directly with the TTA students.

One of the neat things that we do in our ICT class is, during that class, the Warriors to Work Specialist will actually attend the class via remote somehow and walk them through the process of creating their resume. So, they get their resumes created right in that very first class. That way, they're in the Warriors to Work system, and we can reach out to that person, if we need to, to help them find a position.

Another neat thing, for those people that have gotten jobs, the average salary that we are seeing right now is $38,000. And that is a pretty decent starting salary for these warriors.

So, that concludes the briefing

that I have. What other questions do you have that I haven't answered so far?

MEMBER REHBEIN: Sir, I guess the thing that I am most interested in, I can envision other areas outside of the IT field where these kinds of services could be offered.

But what I guess I would like to know is, are there hurdles to get approved to come onto base to offer these services? What kind of hurdles are there, barriers? What can the Task Force to help remove some of those? How did you get this done the first time? How did you get the first approval.

MR. WILLIS: The very first approval that I did, I actually created a slide presentation like this. I got time on the WTU Commander's calendar. I went in and briefed him, the Sergeant Major, Squad Leaders, on the program, what we expected to accomplish out of the program, and was allowed to go in there and do that.

The very first major location that I went to with the brand-new program that we run now was Ft. Bragg. One of the things that we did there, we did it exactly that way. As a matter of fact, they contacted us and asked us if we come in and present this to see if it was something they wanted to do.

We went in; we actually ran, instead of an eight-week session, we ran a four-week session. So, it was compact a little more. And the students actually didn't like it. It was too fast. They had trouble catching everything. They wanted us to slow it down a little bit. So, we are using the current model that we have now of eight weeks for the ICT course.

From there, the word got out to those commanders during their little briefings, and more locations wanted us to come, to the point where they were asking us to come to the WTU and present, so that we could get on base.

The difficult part for us is that there is just no classroom space available. The education centers don't have it. The soldier family support centers don't have it. The WTUs don't have it. There's just no classroom space.

And there are so many other organizations working on post that you have your space time, these two hours, these three hours, and that's all you have. If we had more space and we could offer this at more locations, then we would probably do that.

Does that answer your question?

MEMBER REHBEIN: Do you find that, as the leadership of a WTU changes, that you have to resell your program?

MR. WILLIS: No, that's not the case at all. Most of the time, the exiting Commander has already briefed the new Commander, and we have pretty good success. So, it hasn't been an issue at all.

DIRECTOR DAILEY: For your four

core classes, Mr. Willis, do these core classes prepare them to take the test in these areas? Or is that kind of self-taught and your core classes are introductory, and it kind of gets them interested? And it kind of allows them to think if they want to move forward with serious preparation for these classes, for these tests?

MR. WILLIS: Well, the ICT course is actually the preparatory course. It gives them an opportunity to see if they want to go into IT.

DIRECTOR DAILEY: Okay. Which one is ICT, the introduction, the first one?

MR. WILLIS: Right, right, the first one. Now all of those courses say "Introduction to...."

DIRECTOR DAILEY: Yes, yes.

MR. WILLIS: And it may be a little deceiving. A+, the computer repair, the computer networking, and the security course, they all prepare those students for

the exam.

DIRECTOR DAILEY: Okay. Okay.

MR. WILLIS: We have lab simulators.

DIRECTOR DAILEY: Okay.

MR. WILLIS: We have test databanks. This is not an eight-hour-a-day job.

DIRECTOR DAILEY: Okay.

MR. WILLIS: I can guarantee you that. Our instructors are there all hours. They're always available. They will even go to a hospital bed, for Pete's sake, to make sure that the warriors are prepared.

DIRECTOR DAILEY: Okay. All right. Yes, the introductory terminology was not jibing with -- these are actual preparation. They should be able to walk out of the computer repair class A+, they should be able to walk out of Net+ and Security+ and take the test and get certification?

MR. WILLIS: Yes, absolutely.

DIRECTOR DAILEY: Okay.

MR. WILLIS: The reason we call them "Introduction to...." is because getting the A+, the Net+, and Security+ is an introduction to IT.

DIRECTOR DAILEY: Right.

MR. WILLIS: It's the very first thing that you have to have.

DIRECTOR DAILEY: Okay.

MR. WILLIS: There are a lot of other certifications, but this is the very first one that you need to go on a little bit further.

DIRECTOR DAILEY: Okay. Any statistics? We didn't know what we didn't know when it comes to asking and asking you to present for us. Any idea what success rates they're having when they're taking these tests?

MR. WILLIS: Yes. So far, we're well above the 85 percent that we set four ourselves.

DIRECTOR DAILEY: Okay.

MR. WILLIS: We have key performance indicators within the Wounded Warrior Project that we have to meet --

DIRECTOR DAILEY: Okay.

MR. WILLIS: -- that we have to show our Board of Directors.

DIRECTOR DAILEY: Okay.

MR. WILLIS: And we're well above that 85 percent.

DIRECTOR DAILEY: So, your goal is, if they're taking A+ and they test, that 85 percent of the people will pass it?

MR. WILLIS: That's correct.

DIRECTOR DAILEY: And they will get that certification?

MR. WILLIS: That is correct.

DIRECTOR DAILEY: That helps you ensure your instruction techniques are working.

And help us with, what are the barriers for Service members? Help us

understand what could we do better to prepare them to be in these classes? How do you screen them? Or what type of screening process is there?

MR. WILLIS: The only screening process we do is the Introduction to Computer Technology course. We're not going to turn anybody away.

DIRECTOR DAILEY: Yes, I understand.

MR. WILLIS: One of the really neat things is, as I talk to students, they go into the very first course and they'll get a few weeks into it. And, you know, "Mr. Willis, I don't know if I can really do this. You know, I'm an infantry guy" or "I'm a diesel mechanic." And my thing is try it.

DIRECTOR DAILEY: Right, right.

MR. WILLIS: If you can't do it, we'll let you know.

DIRECTOR DAILEY: Right.

MR. WILLIS: If you can't do it,

you're going to figure it out. But at least try it.

DIRECTOR DAILEY: Right.

MR. WILLIS: This is not their area of expertise. Like I said, they know how to send an email. They can surf the internet.

DIRECTOR DAILEY: Right, right.

MR. WILLIS: But, as far as taking care of their own computers, not very good at that.

We don't want to turn anybody away, but at the end of the Computer Technology course, the very first course, if they really are not a good fit for this kind of an opportunity, an IT opportunity in jobs, we'll definitely let them know. I don't know of a case yet that we have done that.

DIRECTOR DAILEY: Right. And on this slide, your 251 transitioning have been placed in employment. So, what's your denominator? When you're talking to your Board saying, "We've placed 251 in

employment," what's your denominator? These are the ones who are actually interested?

And we hear this a lot. We talk to the WTUs and we say, "So, who's interested in being employed?" That becomes the denominator, right? "And then, how many have you been able to employ?" And that becomes the numerator, and we are able to kind of assess who's employable and what the success rate is.

MR. WILLIS: That's a really good question and, actually, a really hard to answer.

DIRECTOR DAILEY: Yes, yes.

MR. WILLIS: We don't seek them out to find out if they want jobs. More, they come to us. However, when a job description comes out through one of our Warriors to Work folks, they will send it my instructor team. And my instructor team, then, will set it out in the classroom.

This number is probably a little

bit deceiving. It is actually a very high number. These are people that have gotten A+, Net+, and Security+ certifications over the years.

The second thing, we don't know, and there's no way for us to track, how many people have actually changed from their current career field into an IT-related career field in the military. So, that's a success that we can't put a number on. We can't get that information from the Commanders, Transition Coordinators, or anybody else. If we had that number and we could get that statistic, I think you would see that number would rise a whole lot.

Another part of this number that you're not seeing is how many of these people have actually gone into school, have gone into college or a technical school, because of the training that we have given them. That is another one that is very hard for us to get a grasp on. We can do this through our surveys,

but it is very difficult for us to get that number.

MEMBER DRACH: Richard, also, this tracks only those that were placed by the Warrior to Work team?

MR. WILLIS: Correct.

MEMBER DRACH: So, if I go through the course and I go out and get a job on my own, that's not included in the 251 and you can't track them, either.

MR. WILLIS: Right. That is the last thing I was going to say. Absolutely.

DIRECTOR DAILEY: Okay. So, these 251 actively worked with your employment team for employment?

MR. WILLIS: That is correct.

DIRECTOR DAILEY: And you were able to gather their entry salary and track them into that first job?

MR. WILLIS: That is correct.

DIRECTOR DAILEY: Okay. And so, not everyone who comes into the program, then,

seeks that service from you, that employment next-step service from you?

MR. WILLIS: That's true.

DIRECTOR DAILEY: So, we have about 10 percent, and I'm only bringing that up because I did the math real quick, who -- and it's an interesting number, if you place that in the numerator, 2622 in the numerator, that's about 10 percent. And now, all I'm doing is trying to assess, then, who in this workforce -- it kind of gives us a little benchmark about who has interest in IT and how successfully they can be placed. Because I think that 251 could also be both a numerator and a denominator, being 100 percent who are interested and pursued employment in IT were successfully placed.

MR. WILLIS: Uh-hum.

DIRECTOR DAILEY: But, out of the whole population, you really would basically have 10 percent who said took advantage of that opportunity?

MR. WILLIS: Well, I think that number is a little bit skewed in the fact that a lot of these people don't get out of the military, and we don't know that. So, you're going to have drop that number down, the 2,000 down.

We don't know who got jobs on their own. We don't know who went to school. All of those are successes. So, we can't really use that as a 10 percent. I think that we are probably looking at higher to 40 percent or a little higher than that, from the people that we know.

MEMBER REHBEIN: We've got a fair number of Reserve component warriors whose injuries/illnesses are not letting them go back to their normal job, the job they had before they were activated/deployed. I understand that your training methods don't allow you to do distance learning because you want to do hands-on instruction. But, if they can get to you, are they able to get into the

courses or is that something that has to be done through the active-duty WTU?

MR. WILLIS: Yes, you all are probably going to be really upset with me because I didn't put this as part of my briefing. But we actually just started an online learning environment this past year, and we have been very successful at it.

If you taken an online course, you know that they give you a week's worth, a module worth of material that you have to do. And you get that done. You talk on forums, do your assignment, turn it in. The instructor grades that assignment.

We do the same exact thing. However, all of our classes are still instructor-led. So, for three hours those students are online with the instructor and the other students. So, they are still getting that peer support that they get inside the classroom. So, we have modified our online learning. So, those folks that are in

their home and they want to take the course, they can do it now.

We rolled out our A+ course in March. We're doing ICT only right now. We wanted to make sure we worked out all the bugs. We did, and in March we start the very first ICR course.

We lab simulations and things like that. Instead of them actually having hands-on, they will do lab simulations during that class. But we are doing a class just like that.

We have had students from Hawaii, New Mexico, all over the place, Germany, taking these courses now online. And our success rate has not changed.

MEMBER REHBEIN: Most of those certification tests, then, are also a proctored test where you have to be at the test site.

MR. WILLIS: Yes, we don't administer --

MEMBER REHBEIN: For those that are doing the online learning, is there a way for them to take the test without having to travel long distances?

MR. WILLIS: Yes. There are testing facilities in all different cities, and we don't administer any of those tests. Every one of our students, we hand a voucher to them and they go to an independent testing facility and take that exam. So, the online students will have the same opportunity as our classroom students.

DIRECTOR DAILEY: And I heard you say you give them the voucher for these tests, I mean, because they can be expensive, $150, $250, to sit down and take --

MR. WILLIS: Three hundred and forty-five per test.

DIRECTOR DAILEY: Holy cow. Okay.

MR. WILLIS: And, yes, we do give them all the vouchers.

DIRECTOR DAILEY: Okay.

MR. WILLIS: We actually have an agreement with CompTIA and they gave us a gift-in-kind of over 5,000 vouchers for our students. So, all we do is we submit their name and we send them a voucher number. They, then, take that voucher, call the testing facility, and set up their test.

CO-CHAIR CROCKETT-JONES: Are you comparing yourselves to industry-offered courses, success rates, things like that? And how is that looking?

MR. WILLIS: Yes, the standard rate that CompTIA gave us for A+ is about 75 percent pass rate. For Net+ and Security+ it's about 72 percent. And we are well above those at 85 percent and above.

I think the big difference with ours is, you know, our classrooms are not Charlie Brown's teacher up there. They're not standing at a podium and giving the class. They're actually behind the students and they're walking the students through it.

Those students have peer mentors sitting right there with them to help them get along with the material.

If our instructors need to go out and help a student, they need to meet with them one-on-one, they do that, and that's not something that you see in a lot of tech skills, ITT Tech or places like that. We don't charge anything. So, it's easy for us not to do that. With them, they're looking for money; we're not. We're looking for success.

CO-CHAIR CROCKETT-JONES: Any more questions? Okay.

DIRECTOR DAILEY: One more time. In the locations where you're at, if you haven't been able to get on-installation support, do you think being at a Regional Office is deterring participation?

MR. WILLIS: I'm sorry, the last part?

DIRECTOR DAILEY: Yes. Do you

think that being off the installation deters participation?

MR. WILLIS: I don't know yet.

DIRECTOR DAILEY: Hard to say? Yes.

MR. WILLIS: We just started this. I think what you're going to find is that our marketing team has set up a pretty good marketing campaign to get students into the seats. And we have had so many students reach out and say, you know, "I'm not allowed to be on base anymore. Are you going to offer this at different places?"

So, I don't think we're going to have any difficulty. I really don't. We may see our numbers drift a little bit, but I think they'll pick right back up.

DIRECTOR DAILEY: Other than the moving to Nashville and Phoenix, I mean, that's a good question: pent-up demand, delayed, you know, wait lists, anything like that for your program?

MR. WILLIS: Online, we have a huge wait list for online.

DIRECTOR DAILEY: You have a huge wait list for online?

MR. WILLIS: Yes. I actually have a job out for a second online instructor right now. I've got about 80 people waiting for the Introduction to Computer Repair course and over 100 waiting for Introduction to Computer Technology. So, I've got to get another instructor onboard for that.

As soon as we put it out -- we actually it out in Regions to a very small population because we didn't want to get inundated, and it happened anyway.

DIRECTOR DAILEY: And you are advertising to wounded, ill, and injured or anyone leaving the Service? I mean, your Charter kind of drives you to the wounded, ill, and injured?

MR. WILLIS: That's what we would like.

DIRECTOR DAILEY: Yes.

MR. WILLIS: However, there are some very good instructors out there that want to do it for the right reason. You know, if you're here to make a name for yourself, you're going to the wrong place. But, if you're here to help warriors, that's the guy we want. That's the lady we want. We want the one that is going to devote themselves to what we do it and how we do it and why we do it. So, that's the person we're looking for.

DIRECTOR DAILEY: As a student?

MR. WILLIS: Instructor and student.

DIRECTOR DAILEY: Instructor and student. Okay.

Yes, I mean, if you open it up to the 250,000 people a year who leave the military, end their contract, redeploy, that's overwhelming.

MR. WILLIS: It absolutely is.

CO-CHAIR CROCKETT-JONES: Thank

you, Mr. Willis.

MR. WILLIS: You're very welcome. And that was a lot easier than I thought it was going to be.

CO-CHAIR CROCKETT-JONES: We have 10 minutes until our next presenter or are we ready?

DIRECTOR DAILEY: They are here. The IPO office is here, and we'll take a few minutes just to get them set up, but we're on time to start in a couple of minutes.

(Whereupon, the foregoing matter went off the record at 10:51 a.m. and went back on the record at 10:57 a.m.)

CO-CHAIR NATHAN: Okay, we'll go ahead and get started with our next presentation.

So, this next presentation for the Task Force will be given by Mr. Christopher Miller and Dr. Stephen Sears.

Gentlemen, how are you today? Good to see you.

They are going to be speaking in regards to the Interagency Program Office, the artist otherwise known as IPO. Mr. Miller is the Acting Director for the IPO, and Steve is the Chief of Staff. They are going to discuss the new mission and the Charter of the IPO as well as the implementation of new integration and collaboration efforts. Please refer to tab K for their information.

Mr. Miller, as you start, I've looked at your slides, and we look forward to them. But kind of give us quick the "IPO for Dummies" overview of what the general gist is of what the IPO is doing.

MR. MILLER: Yes, will do, sir. Thanks for the time.

So, I guess my first comment to everybody is, whatever you think you know about the IPO, please forget. We are on Version 3, maybe 4, depending on how you think about how we are trying to solve this really important problem. But many of the things

that you may have heard previously about the IPO or IEHR, I would ask you just to kind of forget and move on.

Because at this point I want to kind of walk through sort of what the two Departments are doing. I actually wear two hats. On one side, I am the Program Executive Officer for Mr. Kendall, Under Secretary for AT&L, managing a portfolio of health IT programs. The biggest, of course, is the DoD's modernization program of its Electronic Health Records.

But on my other hat, I am the Acting Director for the Interagency Program Office. We refer to it as the IPO.

Let me just give you the Reader's Digest version of sort of what the IPO does today and kind of quickly talk about some things. A year ago, if I were to be up here, I would tell you the IPO was literally a multibillion dollar acquisition to provide a single system across the VA and the DoD. But

in this past year, both Departments have basically come to some hard decisions, been through a lot of storming and norming and figuring out. And so, today what I am up here to talk to you about is basically how each Department is going to modernize its own systems and, then, the role of the IPO in making sure we do that right.

And the IPO, basically, as I'm going to talk about today, is really a technical organization focused on how we make sure that we're sharing information in a seamless manner, that things are flowing, and that we're basically making sure that all of our veterans and our Service members and people -- you all know the horror stories; you all know what happens. But we're trying to get at the problem of how you share medical health information.

It's important that everybody understand that what I want to talk about today is an EHR, an Electronic Health System.

This is what clinicians use to do their day-to-day job. EHRs do not equal the service treatment record. Do we all have an understanding of sort of how that fits?

Because I think it is important; it is an important clarification because there's lots of discussions right now about backlog and STRs and all those things. The EHR system is basically what runs our hospitals. It is what our clinicians use. It is what our people go into. It is where you go to get a lot of information about what is going on. It is a very detailed system. It is an operational system that is supporting a lot of things that happen throughout our military health system as well as the VA system.

But it is not directly what gets provided when people move from active status over to the VA. So, I bring that up just so everybody kind of understands they're related and they support each other, and there's a

relationship there. But I think it is important we all understand what we're talking about today.

The best equivalent I ever can come up with when I try to explain to people what we're talking about for the medical community is basically like an enterprise resource planning system -- think SAP, Oracle, ebusiness -- for our medical community.

This is a very complicated system. It does a lot of things. It has a lot of capability. And that is kind of what we're going to go through.

But it is also important to keep in mind that this is an emerging IT area and it's important that we have a lot of smart people like Captain Sears and other people that are making sure we're doing the right things.

Just so you understand, you know, a little bit about me, I have been in the job a little over four months. I had a great job

previously. I was living in Charleston. I was running one of the Navy Warfare Centers. I had been a PEO before. I thought I had that box checked. And then, I got a call from Mr. Kendall saying, "I need some help."

And so, I'm coming at this from an acquisition/IT background because that's kind of what I have done my entire life. But I'm lucky that I've got a lot of smart clinical people like Captain Sears and a whole bunch of people that work with me to make sure we're doing the right thing.

That's kind of the quick and dirty. I will quickly go through some slides. Captain Sears has got some slides.

But, more than anything, I would just ask, let's just have an informed discussion. I have no problem answering questions. I know it is hard subject, and I know that you have probably been briefed previously. So, some of these things are probably going to be new and probably

different, and there's probably a lot of things that are not well-conveyed in slides that we could more easily and effectively deal with in sort of an open dialog.

So, this is what I will go over. I think I covered most of this. I'll talk about sort of what we do on the DoD side. I'll talk about the Interagency Program Office, which is still a joint organization between us and the VA. And then, Captain Sears will get into sort of the details on what the IPO is doing. So, that's what you asked the most questions about. And then, we'll kind of go through some questions and answers at the end.

So, real quickly, what are we trying to do here? At the end of the day, what we are really trying to effect is really improving how we provide healthcare across both the DoD and the VA. And one of those big things is looking at this as a multinational problem.

I mean, a lot of people get focused on what we share between the DoD and the VA. But, when you look at the data, over 60 percent of our healthcare -- and the VA has a similar statistic -- is actually performed out in the commercial sector. And these are through the managed care contracts that DHA awards. And so, this is problem that we're really trying to drive at really gets at more than just sharing of information between the DoD and the VA.

It has actually got to be a problem that we think at the national level because any of you that have been out to meet your private care provider, you've got the same challenge if you ever move from one city to the next city. Well, it is very similar to the problem that our Service members are facing.

The adoption rate of Electronic Healthcare Systems like EHRs out in the commercial world is ahead of the projections.

This has been a number of different factors, but they are on a pace right now to basically to be at the point in the next few years where just about everybody's medical information is being contained in some kind of Electronic Health System.

Our first big thing, besides dealing with that interoperability and data-sharing, is really just modernization of our current systems. As I mentioned earlier, the IPO had this task. And I would just be here to tell you that, you know, running a joint program in the Office of the Secretary of Defense is hard enough, but trying to make that work with another agency is even more difficult.

And I think what you saw previously back in February, when the SECDEF got involved and the Secretary of the VA got involved, I think there was some realization that we really need to step back, think about this, and think about how to smartly move out.

Because I think everybody understands the urgency, but I think we are coming at it from slightly different perspectives, and we have got to figure out a smart way to move forward.

MEMBER PHILLIPS: A quick question. I may be jumping way ahead.

MR. MILLER: That's okay.

MEMBER PHILLIPS: But, as you modernize the software, as you upgrade the software, is there a plan to upgrade the hardware and the training? Because we know that one has to follow the other.

MR. MILLER: So, on the DoD side, I will tell you that our acquisition strategy is to pursue a competitive approach. As part of that competitive acquisition strategy, we are going to be asking industry to propose how they are going to meet the requirement from a hardware perspective.

I will tell you that in the commercial world most of this is not running on local hardware. Most of it is accessed

through tablet devices like iPads, through laptops, through almost any kind of device.

Kaiser Permanente is probably the closest example in terms of size and scale as far as somebody that does something similar. They run their entire operation out of two data centers. They do not field stuff locally. There are local devices. You know, obviously, your imaging devices and other things, but they are all connected to the network, and that feeds back to these data centers that actually host the software.

As far as training, change management, supportability, that is where the majority of the cost and the emphasis is in our acquisition process. Because, you know, the actual material procurement is less than 10 percent. What is really important here is how do we get about really thinking about standardizing our business processes and our workflows, and making sure that we can go train those and get them effectively deployed.

Again, a great analogy is, you go talk to anybody who has been through a major financial transition with an ERP, they go through the same kind of process.

Real quickly, the last bullet up there in our goals is to really engage the national level. The big player at the national level is under HHS. It's called the Office of the National Coordinator, which this group, basically, goes out there and figures out for the health community all the various standards that we need to be engaged with. And so, when I say "standards communities" here, these are some organizations like HL7 and some other people that are sort of unique in the community, or unique to that respective community, but there's also some larger standards bodies that they're involved with. But we want to make sure that we're a player there. Because, when you think about the size and scope of DoD and VA combined, we believe we have a lot to offer.

On the acquisition side, or actually buying things, a couple of near-term things: the IPO wrapped up a bunch of near-term improvements in terms of our interoperability. And you will hear things like Joint Legacy Viewer and some other things that we have done to improve the interoperability. And that has been a good win for us. We got asked to go do that, and we did that.

And then, the longer-term piece, the DoD, like I mentioned, is going through a competitive acquisition process. The first draft RFP will be out this week to kind of get some feedback from industry, kind of give them a sense of where we're headed.

And then, you see the VA is on a path to modernize our VistA system. And this is kind of what I was getting at, that both Departments were kind of in a different place. You know, the VA had a large base with VistA. It was their system that they had been using

forever. Whereas, DoD had a collection of systems, and we kind of felt on the DoD side that we would get more bang for the buck if we were to go through a competition. But we are very much open to solutions that build upon the VistA baseline.

And then, moving forward, I would just tell that the VA and the DoD are -- go ahead, sir.

MEMBER PHILLIPS: Again, a quick question. With the open competition, will you be reaching out to other government agencies that have experts in this area? I know you want to maintain the commercial aspect of this, but there is a lot of internal folks that can help out?

MR. MILLER: So, we have already reached out. And so, I have already had ONC involved. I've already had VA involved. It is a competitive acquisition. So, it is obviously targeted towards our industry partners, and those partners include both

people that make the commercial systems, the Epics, the Cerners, the Allscripts -- you know, there's about more than 20 of them -- as well as people that provide the training and the deployment support, and all those things.

We welcome the engagement by other government agencies, but, obviously, you know, we are trying to keep this thing kind of moving on a pace to meet the 2016 timeframe.

Like I said, the bottom bullet here is we're continuing to work with the VA. Not a day goes by that I'm not talking to them or we're co-staffed in the IPO. You know, they contribute to our efforts; we contribute to their efforts. We do still partner on a lot of things.

But what you see here is it's really more of we're collaborating and partnering by a single organization trying to deliver a single system. I think that's the big takeaway here, is that we have kind of rethought the problem. We are trying to make

sure we meet the congressional mandates, and we are trying to make sure we move out smartly.

And I think what you're going to see over the next year from both Departments is you're going to see a lot of forward progress. Both Departments have recognized that we've got to collectively do the right thing here and start moving.

So, I'm pretty excited. As I say, I've been on the job four months. A lot of great things have happened. And I think you will see a lot of continued collaboration and movement here.

MEMBER REHBEIN: Sir?

MR. MILLER: Yes, sir.

MEMBER REHBEIN: If I may quickly, one word. When you talk about the VA modernizing their capabilities, their existing VistA program, can you give me a little bit more definition of what you mean by modernize?

MR. MILLER: So, they have their

VistA system that they have used for some time. And so, what they're in the process of is going and looking at what the user interface looks like as well as standardizing VistA currently. I mean, currently, there are multiple versions of VistA out there. And so, they're looking at both standardization to get to a more common baseline; they are looking at refreshing their user interfaces, as well as bringing in some new functional capabilities that make it on par with some of the commercial offerings out in industry.

So, I mean, again, I can't totally speak for the plan. They're still finalizing that. But, for the most part, they're trying to make sure it can meet the Meaningful Use requirements and some of the other functional requirements that their users are looking for.

DIRECTOR DAILEY: And, Mr. Miller, you say, "Anticipate VistA-based solutions to be part of the competitive." So, those companies and organizations providing VistA

services to the VA could very well come into this competition and offer solutions that would be agreeable or maybe competitive. And in some strange world, they may be the most qualified lowest bidders, and we end up in the VistA world anyway.

MR. MILLER: We could. I mean, I have no dog in this hunt. I'm not sure if you read my bio, but I have never been in the medical world. So, I don't understand all this stuff completely.

I will tell you, from an acquisition perspective, I really don't care. What I care about is how much of the taxpayers' money we spend.

And for those of you who aren't aware, the VA has gone through an effort to open source their software baseline. And so, what we're looking for here is potentially some people out there that might take that baseline and propose it.

But, I will tell you, at the end

of the day I'm a pretty simple guy. You know, I'm a Marine. And so, my mission is I've got a set of requirements. I've got "X" amount of money, and I'm just trying to find a solution at the end.

I really don't want to get into all the politics and everything else because it will give me a headache, and, you know, that's just painful.

But that's kind of where we're at. And so, we have had a number of industry days. We've had a number of discussions. And I think we will see proposals coming back on that. But, again, I've got to honor the process here. That means put the right smart people in the room, let them work through the source selection and find the best value.

MEMBER PHILLIPS: You mentioned during your introduction that there's a huge civilian medical input. Will you be looking at bids that will include the harmonization with the civilian sector?

MR. MILLER: Harmonization is a difficult world, a difficult word choice there. I would tell you, what we're looking for is, obviously, interoperability is an important piece, right? So, we want to be able to have interoperability with the commercial sector. But the commercial sector is still evolving. And so, there is not a single answer out in the commercial right now. ONC is driving some standardization, and we're on that path with them, as part of Meaningful Use.

The most important thing that we want to have is full interoperability with the commercial world. But I will tell you, the commercial world, it is still sort of sorting its way out in terms of capabilities, in terms of the vendors and the providers.

What I'm after is competition. I mean, I'm going to be kind of ruthless on this one to some degree because I'm trying to really save money. And I think what we're

trying to get at is make sure I meet those requirements for things like interoperability, but I want to let the system play out, so that we really do get the best solution.

MEMBER PHILLIPS: Well, the objective of the civilian sector is a bottom-line objective. I mean, they purposefully have firewalls and blockades, so one hospital system can't communicate with another. And that is really counterproductive. So, I would just mention that.

MR. MILLER: Yes, and a lot of that is being addressed by where the Meaningful Use standards are going. But, I mean, I will be the first to tell you that, you know, even some of the large people like Kaiser, they're still trying to figure out, even though they're all on one system, this is why it has been sort of fascinating. Even some of these big organizations that deploy a single system and could have a lot of sharing, they're struggling to your point, to be able

to fully share all that.

But we're trying to drive that. You know, I'll tell you, if you read our RFP, the interoperability piece is not optional. We are trying to very much mandate that whatever we got after has got to be fully be able to share information with the VA.

Now it's a lot of data, right? I mean, it is kind of staggering how much data we do share. People don't recognize today we already share over a million lines of information every single day, right? So, I think it's important that everybody recognize it. It's not just about sharing data; it's actually about having useful data.

And that is really what we're trying to also drive at as part of this process, is get beyond just sending tons of information and really start making those things meaningful and useful on the other side.

MEMBER PHILLIPS: That's a good

point. I mean, scanning doesn't really work.

MR. MILLER: Right. And I think that's a realization. And that's why it has been an interesting dialog with us and Congress, is because we're trying to tell folks, you know, we do share lots of data. The question is, how effective and is it useful?

And so, I think that is the maturity that we are starting to finally have. And this is also where the standards are coming in, because now there are starting to be standards that we can all use for how we map things and how we exchange data.

And it is actually kind of fascinating. It is very similar -- in my previous life, I did C4I programs for the Navy -- it is very similar to the problem in the intelligence world was solving right after 9/11, because you have lots of data. You're trying to figure out how to have a reference point in terms of how things all correlate and

what they mean. And so, it's a very similar problem.

And so, the positive thing for me is I don't think we've got a lot of technical issues. I think our biggest issue is a lot of process things and figuring out how to get things connected. And so, I think we're on the right path. And that's kind of why I'm upbeat about what is going to happen over the next year.

DIRECTOR DAILEY: And I apologize, one more question. ONC, can you give us what that --

MR. MILLER: That's the Office of the National Coordinator underneath HHS.

DIRECTOR DAILEY: Okay.

MR. MILLER: So, what ONC does is ONC is basically the people on behalf of the overall government, the federal government; figures out the Meaningful Use criteria, and they're the people that certify these various commercial systems to make sure they're

meeting the criteria.

This goes into some -- and I'm not going to get on all the details; the Captain is here maybe to help. But there are a lot of incentives and things tied in the outyears to the commercial world for basically having a modern Electronic Health System that meets their standard.

There was initially money set aside for these companies. And on the back side, there will be basically penalties if the commercial systems do not meet certain standards later on down the road.

They are not a standards body. I think it is important to understand that ONC is who coordinates it. They sort of cultivate it, but they're not a standards organization.

Real quickly, on the organization chart, you can't have a DoD presentation without an org chart. So, there's me at the top. And then, basically, I've got three, if you think about it, three offices that kind of

work for me.

The one on the left is that big modernization program. That is the one that we are actively working right now and are going to start seeing things.

The one in the middle is basically a bunch of near-term interoperability efforts with us and the VA. I hate to throw out acronyms, but these are things like BEE HEE and FEE HEE. And there's all these different exchange mechanisms that we have today that we're trying to modernize, so that we can improve the usefulness of the data exchange.

And we're trying to do some things over the next couple of years to make it better. So that, when I actually do deploy the follow-on modernized program, it actually goes out faster.

And it is actually kind of a complicated slide -- I probably could have given you a headache -- all the different ways things flow and how they flow. And so, we're

trying to do some near-term smart things in the interoperability space before that.

And then, there is the IPO, which, as I talked about, they really are the single point of accountability in terms of technical standards, specifications. A good analogy is they are sort of like NAVSEA 08 in the Navy, right? You know, NAVSEA 08 doesn't build carriers; they don't build ships, but they make sure that they're built to the appropriate standards. They measure and do all the right things.

And that's kind of our model here. And so, Captain Sears will kind of go into some details about that.

The IPO actually reports to both Departments. And so, on one hat, they report through me up to Secretary Kendall. And then, on the VA side, they report up to the VA's OI&T, which is their IT organization. That is sort of the best equivalent to the DoD acquisition side. So, it is CIO plus

acquisition over there, and that's who they report to. So, we have a very collaborative organization that comes together and basically manages sort of the day-to-day activities of the IPO.

I won't spend a whole lot of time here. I have talked about all of this, and I think about sort of what is on here, sort of our three goals. But it really does come down to, at the end of the day, you know, really impacting and making decisions better, right?

I'm going to modernize the system, but we are not losing sight of the fact that what we're really trying to do is make the clinicians' life better. And that means either giving them back time, making decisions easier, helping them get their job done.

And you kind of see some things up there about sort of what I have talked about in terms of the competitive acquisition as well as the coordinating or adoption of national standards. And again, I've talked

about everything here, and I would rather kind of let Captain Sears get up here and answer all your really hard questions.

MEMBER PHILLIPS: The middle box, "Provide technical solutions," are you at the point where you can give any examples?

MR. MILLER: I think a great example there would be JLV, so Joint Legacy Viewer. And so, what we have done in that area is that we have basically provided a viewer that can see both records. And so, if you are one of the poly-trauma sites or a couple of other locations, you would be able to actually pull the record up from the VA side as well the DoD medical record and see them side-by-side.

And this is kind of interesting because, as I am finding out, there's a different culture in the medical world. And so, one of the things we're starting to find is, even though we provide that information, we are still trying to work through how they

will deal with that information.

There is this whole trust but verify kind of thing out there. And so, we have done some really great things. And I think those are the kinds of solutions you will see.

A lot of it has kind of been on the back end in terms of how we share data and how we map the data. But I think one of the great examples would be that JLV.

It's actually interesting because, originally, this was designed for the clinical community. And now, the VA has come in and saying, "Hey, this would be a great thing for our benefits folks." And so, we're kind of working through sort of the challenges there because it does provide a lot of capability. So, a single pane of glass, you can basically see both records side-by-side.

MEMBER REHBEIN: Sir, about a year ago, we were out at the Lovell facility in North Chicago and they demonstrated something

called JANUS.

MR. MILLER: That's the same thing.

MEMBER REHBEIN: Is that the same thing?

MR. MILLER: Yes. Unfortunately, the "J" in JLV is JANUS. So, it is the JANUS Legacy Viewer. There are a couple of minor differences up at North Chicago, but it is the same basic thing.

MEMBER REHBEIN: Good. I just wanted to get all the terms in the right boxes in my head.

MR. MILLER: Yes, I'm with you.

All right. So, looking back, 13, just some of the things that we have done.

You know, the big thing, I will tell you, is we have got both Departments kind on a plan -- and that kind of goes back, and I'll show you a slide here in just a second -- sort of a plan and a strategy for how we're going to move forward.

And I have spent a lot of time with both Departments trying to make sure we're on the same page. And that's something that you will see here in a second.

I just talked about JLV, but we did provide that at seven additional sites, in addition to the two. And we can talk offline if you want to know more about that.

And then, the viewer is one product. And the second bullet up there is really how we have mapped data, and we have mapped seven clinical domains. So, we're all sharing terms.

It is actually this whole mapping of data is quite fascinating. You would think that in our medical communities we would have some normalization. Well, actually, it is kind of crazy. Some are in pounds and some are in metrics. There's lots of different interpretations of how we do things.

And so, one of the big near-term things we are doing is trying to get to some

national standards in terms of data terminology, and Captain Sears will talk about that.

And then, we have also done things with Blue Button. And then, on the Blue Button side, Blue Button basically allows anybody -- it's like a little blue button icon. You go in and you can download your medical record, right? So, this gets to the point where, instead of having, like when I left active duty, having to print it all out, you can now put it into basically a downloadable format.

I will be the first to tell you that there's a lot more we would like to do here, and this is on the DoD side, why we are moving to a competitive acquisition, because industry has taken this to the next level. But we have provided the initial capability.

And then, on the network piece, we have been doing a lot of work to make sure that our networks -- I mean, this gets kind of

to the questions from Dr. Phillips here -- we may all be doing it in the same space, but sometimes our networks don't usually allow and facilitate sharing of information. So, we have been doing some things there to improve.

Now, as far as modernizing, a couple of things have happened. You know, we have already stood up this new program office. It's at the PEO.

We have had two industry days, major interest from our industry partners about what is going on here. And like I mentioned, we're on a path to get our first draft of our RFP out this week.

On the requirements side, which is a very important thing for DoD, we have stood up this functional Advisory Council, basically, to kind of be like a mini-JROC, if you will, that kind of maintains sort of requirement standardization. Because in any of these big IT programs, the requirements management is a very important thing, and it

is important that we really do understand and we keep tight configurations on our requirements.

All right. So, let me just show you this slide. And there is a lot going on here. I'll try to be quick, so that Captain Sears can get up here.

But the very top of the level between the DoD and the VA, there is this group called the Joint Executive Committee. This is chaired by Mr. Riojas, who is acting as a Deputy Secretary on the VA side, and Ms. Wright, who is the Acting Under Secretary for PNR.

That is the most senior body between the DoD and the VA, and they oversee a lot of interactions between the two Departments. One of them just happens to be what we're doing with Electronic Health Records.

But, for that group of people, the requirements come into this thing called the

Health Executive Committee. And so, this is where Dr. Petzel and Dr. Woodson get together with their functional and their clinical representatives, and they basically bring in all the requirements.

And then, on the left, obviously, we have our supporting budget processes. But that group at the top, that JEC, which includes, you know, the leadership of both Departments, is basically who directs where the IPO is going and, also, directs where both modernization programs are going to stay synchronized.

This group meets at least once a quarter, and they've always got a lot of stuff going on because this is, obviously, a very complicated thing.

The sort of more tactical leadership is what is provided by that box just below, which is the DoD/VA Senior Steering Group. And that is chaired by the VA CIO, Steph Warren, and Mr. Kendall on the DoD

side.

That is basically my boss when I am wearing either one of my hats, and it is also who the VA reports to as their senior official. That is the person that or that is the group that meets more regularly, at least once a month, and they are the folks that are basically sort of giving the direction day-to-day.

Then, what you see down at the bottom are sort of the three components, right? And all three of these components work closely together. We're all collaborating. We're all talking. But you've basically got a VA program, a DoD program, and you've got the IPO in the middle.

And the IPO, arguably, is the most important piece because, without the interoperability piece, we're not going anywhere. And so, as I mentioned earlier, that interoperability piece is actually bigger than the VA. It also includes what we do in

the commercial space. But you see sort of what their responsibilities are in terms of adoption and standards and making sure we're doing the right technical things.

And then, down at the bottom it kind of gives you some ideas of what the outputs are and who does what to who.

You know, at the end of the day, there are some things where the DoD and the VA have to agree. We have to have common solutions. And so, we're working on those things, things like our management. DoD has CAC cards; VA, we're working through how they get PIP cards and other things. And so, those are the kinds of issues that we have to work through as well as things like how we do our network and other things.

And then, obviously, you'll see on either side is basically the big acquisition programs. That is kind of how we all fit together, and this is kind of how we all operate.

As I said, a year ago, if I had been up here, I would have showed you this one big program that, arguably, was so complicated and so difficult, it was almost unwieldy, given the complexities of what we're trying to deal with.

DIRECTOR DAILEY: Mr. Miller, so back on page 6, you also talk about another Functional Advisory Council. How does it fit into --

MR. MILLER: So, the Functional Advisory Council feeds this group up here.

DIRECTOR DAILEY: It feeds what group?

MR. MILLER: The Health Executive Committee.

DIRECTOR DAILEY: Okay. And this is the first time they've had one? There has not been a previous one?

MR. MILLER: Okay. This thing right here is a inter-Department level, right?

DIRECTOR DAILEY: I understand

that, yes.

MR. MILLER: So, this is where the two Departments come together.

DIRECTOR DAILEY: I understand that.

MR. MILLER: When I talk about the fact that it is the first time DoD has had a clinical requirements body -- why are you shaking your head? Show me a signed requirement by anybody in the Department that really gets at this kind of thing.

DIRECTOR DAILEY: Okay. I know there are parts of the --

MR. MILLER: We have JROC, right?

DIRECTOR DAILEY: Yes. I know there are parts of the Joint Executive Council that have been working on clinical requirements for a long time.

MR. MILLER: That is the ICIB. ICIB is that body you're talking about. ICIB is, again, an interagency piece.

What I'm talking about is how does

the DoD get its collective requirements together to feed the ICIB, which is another input into the Health Executive Committee.

DIRECTOR DAILEY: Okay. All right.

MR. MILLER: It's complicated. And I'm not making any of this up because a lot of these groups up here are congressionally-mandated.

All right. So, real quickly, I've talked about some of this. On the interoperability side, it is a very close partnership with ONC. Hopefully, one of the things you're taking away from here is that the commercial world is moving very quickly. And so, ONC is critical because ONC is who deals with the commercial sector and the private sector. And so, we've got to stay tight with them, and we've got to make sure we're in partnership.

This will be one of the larger acquisitions. And so, we're trying to figure

out how to partner with them, so that we can help them move their agenda forward in terms of the standards, the data-sharing, and some of those things.

And then, what you're also looking at is we're not crazy. We're going to try to do some incremental things. I'm trying to avoid the big bang because that just kind of sets us up for issues down the road.

But we are also being very smart in terms of how we think about our architecture. We are very committed to an open-architecture approach. We do not want to get locked into a specific vendor. This is an evolving space, and there's lots of competition here, which is good, but we don't to pick beta in the beta/VHS world, right? We want to make sure that we're a little smarter about who we pick and have flexibility to kind of be moving forward in the future.

And so, this just kind of outlines sort of from an acquisition piece where we're

at. And then, I think the next piece up will be the IPO. So, I'll let Captain Sears come up and we continue to just have some dialog and answer some questions.

CAPTAIN SEARS: Mr. Miller, thank you, sir. Ladies and gentlemen, thanks.

I apologize in advance. I'm getting over a cold. So, if my voice is breaking up, I apologize.

A couple of things. Again, I'm Steve Sears. I am the Chief of Staff for the IPO. I've been in this shop about two months now, and previous to that I had many jobs within the IPO previously.

A couple of messages I want to make sure I bring home for you today. No. 1 is that the IPO is all about standards. We're not all about acquisition. We're not all about development. We're all about standards.

And No. 2 is, and probably it should have been No. 1, is we are the interagency group. We're all about DoD and VA

together helping make sure that we get to the standards we want to use.

Our mission objectives, really, again, it is that single point of accountability in the development and implementation of the Electronic Health Record systems. And in this, it is about the standards, making sure that the standards we all select we adhere to; we end up with the interoperable records that we want and need for our beneficiaries.

We are going to lead the Departments' implements these National Health Data Standards. We are also going to be that group that helps monitor and make sure that, as we implement these things, we can report up to our superiors as to how well it's going, how successful we are, and what the end results. And we are working now on metrics to help us look at the outcome side of that as well.

The objectives we are going to

establish, monitor, and approve, this clinical and technical standards, right, because it is not just about technical standards by which things move about. So, there are terminology standards, much like the NLM works on. We need to all be speaking the language, or when we send things back and forth, we won't necessarily understand it. We also need to put those messages that go back and forth between organizations into a common construct, so that when I get a message, I know how to take apart and put into the construct for my place.

And then, in the transition, right, that transmission piece, we have to use common standards to transmit those. And so, it's technical side as well as the terminology side standards will be the only way.

Obviously, we will work hand-in-hand with the group, the Interagency Clinical Informatics Board, which you heard before. That's one. That is the clinical informatics

DoD/VA group of functions that sit and look at requirements, that look at use cases, that look at our needs going forward and help guide us, as well as with the Health Architecture Review Board, those people who help construct and guide and maintain the standards on our technical infrastructure as we go forward.

MEMBER PHILLIPS: Captain, sir, do you have some international input? I mean, the international language of medicine is English, and the standard language of the world, as Mr. Miller was mentioned. Is there some international input for the standards?

CAPTAIN SEARS: So, at this point, we are looking at all the different standards development organizations. And obviously, as you say, some of those are national standards development, but some of those are international standards. And to that extent, yes. We don't currently have any other direct international activity. Will there be in the future? I suspect, given the international

standards development organizations and things, we will have interactions there.

And we're going to represent and lead the DoD efforts with ONC, the Office of the National Coordinator for HIT, again, that group that helps identify standards for the national side, as we work on the DoD side of the house, I'm sorry, the DoD and VA side of the house. And again, we called out the national and the international standards development organizations there that we need to be working with.

New IPO Charter and, you know, you may have heard new IPO Charter a couple of times before. As Mr. Miller said, this is Version 3 or Version 4. This was signed out in December and set us on the course we're on today.

You know, it leverages the Joint Executive Council Charter as a model, so our parent organization; leveraged that legislation that created the IPO. And again,

it scopes us to be a health data standards guidance and enforcement entity.

The thing I would like to point out here, and it's called out here, is that we are no longer the modernization and integration of legacy systems. We're not the acquisition and development side of the house any longer. As you saw on Mr. Miller's chart, that belongs to the other organizations.

So, what are our future efforts. Really, these are the efforts we're undertaking right now. Really three big goals, right?

The data interoperability standards identification and development. Again, what terminology standards, what communications standards are we going to use to move data back and forth.

Working closely with ONC. Our goal is not just to interoperate between DoD and VA, but to create a record and to help drive, as ONC is driving, that record where

all of the data from your health record can be displayed in one place because it all meets the same standards.

Identify and prioritize the data domain terminology, technical standards. We already talked about that.

And then, to our point, it is developing those standard specifications that DoD and VA are going to meet in their modernization and in their acquisition, again, working with ONC and making sure they are the same standards we're using nationally and internationally.

Supporting the data interoperability standards implementation. So, once we have identified them, someone has to help make sure that, as our groups go to use them, we can help interpret the pieces where it is less obvious or where we run into challenges in implementation. And so, we have a division that is going to be working with DoD and VA as they go through that process.

The third piece, obviously, is the monitoring and reporting. It is clearly called out in our Charter as well as in the legislative language that it is part of our job to monitor these implementations across both agencies and to report back on how we're doing, both terminology mapping issues, are we speaking the same language, as well as how effective is that. As we are implementing these changes, how is it affecting the interoperation of data and supporting healthcare really?

ONC collaboration, a big piece. Again, you heard it on slide after slide after slide. It is not just about what do we think the standards are. It is about what are the national and international standards and working with those groups.

Two big areas of ONC collaboration, the first one doesn't belong to me specifically in IPO. This is ONC and our DHMSM, our DoD side acquisition/modernization

side, working with ONC, again, helping make sure that, as they select and go into the competition on their next product, that they're leveraging Meaningful Use and the other pieces that need to be leveraged in order to identify the best choice going forward for DoD.

The IPO, again, that single point of accountability, right? And you have seen these statements again. Identify, draft, and implement the interoperability standards and ensure that VistA and modernization and DHMSM acquisition adhere to those, again, working with ONC, working with the national/international groups.

Yes, I get a lot of questions about, "Well, what are you going to do if and what are you going to do when, and what if there is not a standard?" So, we have dealt with that already. I would offer that DoD and VA in the long-ago timeframe, back more years ago than I care to admit, when I was an intern

and we were installing CHCS brand-new in my hospital, we were on the cutting edge. And we were developing how we were going to do things before such standards existed.

We are lucky now. Lots of standards exist. So, you know, kind of three categories of this world exist, I think, now.

The first is there is a clear national standard or international standard, right, the domains covered by an ONC-endorsed standard, in which case that's what we use, right? That is what commercial should be using. That's what we use, right?

So, that's this pathway, right? And again, it leads us to always continuing to work with the standards development organizations because these things evolve over time. Terminology evolves over time. Technical standards evolve over time, and we need to evolve with them.

The second case is where there is kind of a near --

MEMBER PHILLIPS: I was going to say question --

CAPTAIN SEARS: Go ahead.

MEMBER PHILLIPS: -- about the Health Data Dictionary. It's a 3M product which they have released for use. Will we be able to upgrade that and manipulate it? Are there any restrictions? Do you know?

MR. MILLER: No. It is actually part of our contract. We also paid the open-source parts. So, we have addressed those. But I think as Captain Sears is going to get to, that is an interim solution.

But, to your concerns, yes, that's part of the contract, is to keep it up-to-date as well as make it available to other people.

CAPTAIN SEARS: Thank you, sir.

You know, the second classification is where there is not obviously an ONC-endorsed standard yet, but there is really a near standard. It's almost there. It is the candidate. It is broadly used

internationally or nationally. And in those cases, it is likely that DoD and VA are going to say, "Let's use that near-term candidate and, then, continue our work with the standards development organizations and the ONC to mature it, make sure that it becomes what we all need it to be.

And the third case is kind of that hard case. And that's where really no standard yet exists, either because it is something special to DoD and VA or one of our agencies or because people just haven't gotten to it yet. It hasn't been identified as a need.

And in that case, we do have, as was discussed, we have the HDD, the Health Data Dictionary, which is a product, a 3M product under contract with us, and we can use that to help us do the translation between the two agencies while we work on what is the final standard.

So, at least in the interim we can

interoperate that data while we work toward a final. And again, those arrows all lead to continuing to work with those standards development organizations and the ONC to make sure that we get the standards to where they need to be to support us.

What does success look like? I'll address this one, if you like, sir. I think this is both of our slide. You know, really, for all of us, it's about can the right health data get into the right authorized users' hands at the right time to make whatever is the decision faster and easier, right?

For Service members and veterans, that looks like increased record portability and accessibility. You heard about Blue Button. You've seen patient portal kind of concepts. DoD and VA clinicians, right, it improves their decisionmaking based on integrated patient information, right, not just reams of scanned information and stuff put in front of me, but presenting the data in

such a way that they can efficiently process it and efficiently make a decision, clinical, benefits, whatever the proper decision is, based on that data.

For the IPO, if we become recognized as the health data interoperability authority for DoD and VA, we are effectively a partner with the ONC and the other health data standard organizations. We achieve the SMART objectives and the Joint Executive Committee's Joint Strategic Plan, and we successfully guide our Departments to implement the technical data interoperability standards, profiles, so that that data goes back and forth to support all those other challenges.

The interoperability team, the team that has been putting the technical solutions in place that you saw, delivering those federated data elements iteratively, right, taking all of our standards and effectively making that data move back and

forth from the technical standpoint.

DHMSM, fielding that modernized DoD system by '17.

And for VistA evolution, achieving their initial operating capabilities by October 2014, as they're defining them, and achieving a modernized system at full operational capability in the 2017 range.

So, in the end, it is all about positively impacting those outcomes, right, ensuring that the data is there, that people are able to make the right decisions, and that we positively impact the lives of our clinicians, our beneficiaries, our active military, and our veterans.

MEMBER MALEBRANCHE: I have a question. As part of the Recovering Warrior Task Force, one of the things that I understand Mr. Miller went earlier and said this is about the health record, not the service record. However, I know at one point it was all mixed up together. What has

happened to that piece of, I guess it would have been VLER, because is that under the Benefits Executive Council? Because that does affect for our Recovering Warrior some of that information.

MR. MILLER: Right. So, a couple of things have gone on. HAIMS has been a near-term effort by both Departments, right? That is basically where we are taking the medical record, digitizing it, back to your comments -- today it is a PDF, but we are digitizing that, and it's being sent over to the VA.

So, that is being done by DHA. But that to the end of supporting of STR. And what I was trying to get earlier is the data in the EHR feeds the STR, but they are not exactly the same, right?

Let me give you an example of what I mean. When you go in for an inpatient stay, you know, you're getting lots of data collected on you. But when you go to the STR,

there's like a summary of that stay. There is not all the underlying every single thing that happens, right, because --

DIRECTOR DAILEY: Let me just hold -- STR?

MR. MILLER: Service Treatment Record.

MEMBER MALEBRANCHE: Okay.

MR. MILLER: Because that is what the benefits analysis people need in the VA. So, there is a separate effort between the two Departments called HAIMS to automate that and to make it better.

And I'm not responsible for that, but I can at least give you the sort of Reader's Digest. So, by January of this year, they had completed the initial deployment or starting to do that.

But I would encourage you to reach out to either the VA or DHA and they can come in and give you an idea of what is going on. But there has been a lot of effort over the

last year to make that be a digital electronic sharing, and the program is called HAIMS.

VLER is a little different. VLER is the Virtual Lifetime Electronic Record. There are multiple flavors of VLER, and there are some that's benefits, some that's health. But that is also a national thing. And so, when you think VLER, you have to be thinking about sort of the private sector as well as military.

So, we are using parts of VLER for sharing information with the private sector. And there are different ONC-endorsed product offerings that we field as part of VLER. But VLER is basically part of a national agenda to kind of have some standards for how you share medical information.

Unfortunately, it is kinds of complicated because it does kind of get in some of the same areas as the STR, but it is more done at the national level, and the STR has more information in it for the benefits

people than just to be covered by a VLER kind of exchange of information.

MEMBER PHILLIPS: I would just say that was a great presentation. Thank you.

Obviously, in a perfect world, we would like to have one system for all, but this is not a perfect world.

MR. MILLER: That's way above my pay grade.

(Laughter.)

MEMBER PHILLIPS: And mine as well.

But let me just ask -- and I think I know the answer -- you talked a lot about display of information. Everybody will be able to display and read the information. How about the next step to make that usable, interoperable?

MR. MILLER: So, that is kind of what I was saying about the medical community. And I will let Captain Sears to give his perspective.

But what I have gathered, I think we are going to get to the point where we can provide the data, right, and it will be usable data. But I think there is another discussion in terms of the business process and how willing a medical professional or a clinician is willing to accept, right? I mean, it's that trust but verify thing.

I don't think there is a technical issue here of connecting systems, sharing. I mean, we have proven -- I mean, like I said, it is above my pay grade to say we're going to be one system now -- but we have proven in the technical world, and I don't care what other system you look at, we can figure out how to build the standards and share information, but it is a whole different discussion when you talk about whether or not the clinicians are actually going to use that data as part of their decisionmaking.

And Captain Sears can give his perspective, but I think that is a whole other

debate and discussion area. And that's where Admiral Nathan and some other people can tee up, because that is more, I think, of a functional and clinical discussion than it is a technical discussion.

MEMBER PHILLIPS: I think you're right. I mean, it requires a cultural change. As a cardiac surgeon, I was taught not to trust anybody but myself.

(Laughter.)

MR. MILLER: You're not the first person that's told me that from this community.

CAPTAIN SEARS: As a radiologist, they taught me the same thing.

Sir, I would offer, also, that I think what you're addressing is that next step. At the first step, we have got to get the data that we have in the condition it's in to go back and forth in an effective manner.

And then, the next step is, you know, interoperability is really two parts.

It is not just, can I send you the data and can you read it, but can you do what you want with it. In some cases, all you want to do is view it. Great. That's an easy one. But, in cases where you want to be able to do computational, graphic, you know, as we all talk about in the medical world, this kind of nirvana of clinical decision support where it is able to synthesize some things in the background, look at the literature, and tell me, think about this; think about that. You know, that's those next steps out there that we need to look at how we get to. And I think those are next steps.

MR. MILLER: Yes, and I think it is also important to take away, and as I said in my opening remarks, this isn't just a DoD/VA challenge. I think anybody here who has gone to get care in the private community, you got the same thing.

Maybe you're local, go to a INOVA. They're in the process of deploying it. I

mean, you will be impacted by this and you will want to be able to move your medical record, and you will want to do the exact same things that we're trying to get at between the DoD and the VA in the private sector.

So, that has been the real game-changer. And as Captain Sears kind of highlighted, you know, a decade ago, DoD and VA were at the forefront of this technical area because we had hard requirements. We were trying to solve some really hard problems.

It has changed, and I think if you were to go out and look at the investment, the research dollars, and the things that are happening in the commercial sector, it's staggering right now. And so, the market has fundamentally changed, and I think it is important that both Departments figure out how to take advantage of that and figure out how to leverage it.

I mean, it is very similar to --

you know, I hate to say it, but when I first came on active duty, I was an IT guy. We were trying to build email systems. Eventually, we said, "We can't compete with Microsoft." At some point, I think we have got to kind of have the same realization to figure out how to take advantage of that commercial investment and really get it to where we need to be because we're not all that different.

I mean, this is the other thing I've been really having some hard discussions with the leadership of the DoD. We like to say that we have a lot of hard requirements, but our requirements are not all that different than what the commercial care providers do.

In fact, some of our hospitals don't even push some of the technical requirements that you will see in some of these large deployments, right? Now we do have some interesting things. Like I have got to support forward deployed forces. I've got

to make it work on a submarine, right? There are some unique things, but those things are not nearly as overwhelming as a lot of people think they are.

And I think, with the right kind of discussion on our processes and how we do things, I think we can overcome that and really get a lot of value and ride the wave of where the commercial world is going.

MEMBER PHILLIPS: And I think you're absolutely correct that the devil is in the details. I mean, you're struggling with CAC cards or PVI cards.

As a clinician, I would love to see a hyperlink, say, in a medical record if somebody had a cadaver bone graft or a pacemaker, to be able to track that down. You know, I just mention that as an example.

MEMBER REHBEIN: So, when you talk about increased record portability -- and I'll use the Command Sergeant Major here as an example because he is National Guard -- and

when we are in a high Op Tempo, we've got people going back and forth between active duty and off deployments, I wouldn't be at all surprises in a period of four or five years he has probably received care from the DoD, from the VA, from civilian providers. So, that kind of portability is going to be able to go all directions, I hope.

MR. MILLER: Yes, that is where we want to go. That is our objective, right. So, I think the way you just highlighted it is one of those use cases that we are trying to solve.

I think the simple one, right, is obviously you start in DoD and you go to the VA. Where it gets much more complicated is National Guard, Reservists. But that is exactly where we are trying to go, but it requires coordinations on at least a couple of fronts, right? I think when you're just talking DoD and VA, I could put us all in a room; we could all agree. But when you start

talking about exchanging with the private sector, it gets more complicated, but that's where the relationship with ONC, that's where the national standards are going, things like VLER play in. But that is exactly the problem that we're trying to get at.

So, it doesn't matter where the care is being provided; we can get the portability, so that the information moves and, also, so that the Service member or the veteran has the ability to move their stuff. If they get frustrated with one provider and they want to go somewhere else, they can take it with them as well.

MEMBER MALEBRANCHE: Okay. Any other questions?

(No response.)

Okay. Well, I would like to thank you, Mr. Miller and Captain Sears.

MR. MILLER: Yes, thank you.

CAPTAIN SEARS: Thank you, ma'am.

MEMBER MALEBRANCHE: And the

Committee will now adjourn for lunch.

(Whereupon, the foregoing matter went off the record at 11:51 a.m. and went back on the record at 1:00 p.m.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

1:00 p.m.

CO-CHAIR CROCKETT-JONES: Okay. Welcome back from lunch.

This afternoon we welcome Mr. Frank DiGiovanni, Director for Force Readiness and Training, to discuss job training, employment skills training, apprenticeships, and internships. Mr. DiGiovanni will be updating the Task Force on information provided in April 2013, including the status of DODI 1322.29. Please turn to tab L for Mr. DiGiovanni's information.

I'm going to turn it over to you, sir.

MR. DiGIOVANNI: Okay. Thank you.

So, it has been about a year since I've talked to you last. I think there are some familiar faces in here. I do recognize a few.

But I am just going to go through this briefing. We have an hour, right?

CO-CHAIR CROCKETT-JONES: Yes.

MR. DiGIOVANNI: It may or may not take an hour. I like questions, so don't be bashful.

So, I am going to go through the slides relatively quickly. Please raise your hand and bring a point to my attention if there is something here that you need more information on.

This is the legislation which actually created the DODI. So, this was in 2012. You can see that one of the things that is really clear here is the -- there is the laser pointer -- right here where it said that the program will be carried out in accordance with regulations as prescribed by the Secretary of Defense.

So, this DODI, which is now signed, the good thing I can tell you is that 1322.29 is now a signed and official DODI and is being used. So, that was effective as of 24 January 2014, so just in time for this

meeting.

Some of the things that are in the DODI I do want to kind of cover, at least expose you to them. So, the Secretaries of military departments are the ones that will ensure compliance with the document.

You can see here about providing opportunities, identification of Service members. One of the things that we're going to have to do as we go along is identify and document these civilian sector job training opportunities. And so, there's actually a form in the DODI that we will ask the Services to fill out as people participate, so that we can track what the type of training that is being offered, and then, how many people are participating in the program.

Memorandums of Understanding, this is a best practice. Special Operations Command has been using this authority through the DTM process for almost a year now, in fact, over a year.

One of the things that they do with many of the training opportunities and the intern opportunities is to do an MOU with the organization. So, it is clear as to what authorities, responsibilities, et cetera, that each party has as far as the program.

Methodology, standards for collecting metrics, and, of course, reviewing proposals by the training providers.

So, this slide I think is really important. So, I will spend a few minutes on this one. This really outlines the tenets of the program, and there are several in here, some of them added by lawyers, if you can tell. I don't know how many lawyers are in the room, but there is some lawyer-speak in here, too.

But the first one is that it is voluntary. In other words, the Service member themselves must take action to participate. They will be informed about the opportunity, but the Commander or your Platoon Sergeant is

not going to take you by the arm and say, "Okay, here, let's go participate in this program." It's voluntary. There is work to ensure that the Service member is knowledgeable on the opportunity, but you're not going to get your hand held here.

In fact, if you really think about the program, you want someone who is a self-starter because we'll talk in a minute why that is important.

Authorized by the first field grade commander with UCMJ authority. Why? Because the duty location for this individual could be miles away from the installation, and there is no supervision for that person.

So, this is why I think it is important that the person be a self-starter. I mean, they have to be motivated to want to do this and to complete it.

And the UCMJ piece is to make sure that that individual knows that they are going to be held accountable, because they are a

member of the United States military, to their behavior and completion of the training.

Mission requirements. So, again, this is a privilege, not a right, which means that if the mission can support allowing this person to participate, then the Commander will make that determination.

No conflict of interest, that is a lawyer thing to make sure that there isn't any conflicts between the training provider and the individual or the Department of Defense; undue conflicts, put it that way.

You can be recalled. So, if, for example, a balloon goes up and they put stop-loss in, and you need that individual back, they can be recalled back to their duty location to perform the military mission.

Training must be offered at minimal or no cost. Okay. This is a filter to make sure that they're not doing something that is in the end going to cost them a lot of money with maybe no favorable outcome for the

individual.

MEMBER DRACH: Sir?

MR. DiGIOVANNI: Yes?

MEMBER DRACH: Excuse me. If there is any cost, it is assumed by the Service member, not by the --

MR. DiGIOVANNI: That's correct. The one thing that we put in the DODI is that no appropriated funds can be used for this program, which means you're not going to be on TDY status. You're not going to get anything other than your normal salary and benefits.

MEMBER MUSTION: But you can go on a permissive TDY status?

MR. DiGIOVANNI: Correct. Correct. In fact, it is interesting to see how the Services will do it. We think it will be a permissive TDY because of the timing, but the Commander could just say that your duty location is Location X. But there is no TDY or per diem associated with this program.

And I think the last one, again,

is the high probability of post-employment. So, you want to make sure that, if you are going to let this person go and you're going to get a DoD salary, that there's a good probability that they will actually be employed if they successfully complete the training. So, this is why we're collecting statistics, because we have to understand the efficacy of the program.

But I think these are really the key tenets of it, and it also puts providers on notice to say, look, this isn't free, good. I mean, we're looking for training. You need to make that investment in the individual. And, too, there needs to be the potential for a job at the end of the training or internship.

MEMBER PHILLIPS: Would this cover certain technical schools where they'll train you and they promise we'll get you a job afterwards? Or is this directly with an employer?

MR. DiGIOVANNI: The technical school issue, it depends. Most of the technical schools will not give you training for free, right, or at little or no cost? So, it doesn't really -- it is not designed to teach that.

What it is designed to do is -- I can give you some examples. So, there is an apprenticeship program with the Pipefitters Union at Ft. Lewis-McChord. Okay? I think it's a 16-week training course. It's offered at no cost to the individual. They leave normally with a certification and a promise for a job. And I think 100 percent of their people, if you successfully completed and decide to move forward, are placed. That's the kind of program we're talking about.

I've got another program where we're working with the construction industry, and we're not talking like small construction, but big construction, highways, bridges, things like that, the large buildings. They

will provide training for free and, then, place you in the construction industry. And the companies are like DynCorp, Fluor, Techtel, I mean big companies.

And so, those are the types of training opportunities that we are talking about.

MEMBER DRACH: So, are you working at all with Helmets to Hardhats?

MR. DiGIOVANNI: Yes, we have worked with Helmets to Hardhats. In fact, I also worked with the Guard and Reserve on Heroes to Hired. Also, in fact, I just took a briefing from them earlier this week.

But, again, what we are looking for is companies, industry, that are willing to invest in a Service member because that Service member's capabilities has value to the company. That's what we're looking for.

Any other questions on that slide?

MEMBER PHILLIPS: One quick question.

MR. DiGIOVANNI: Sir?

MEMBER PHILLIPS: The 180 days, I mean, how does that number come down in the Service?

MR. DiGIOVANNI: The temperature of the water in talking to the Services is that six months is going to be a pretty hard push. The program is authorized by law up to six months. We think that in application it is probably going to be somewhere in the 120 to 90 to 60 days. It will be hard to get someone out six months prior.

We don't know yet because the only people that have used this authority so far has been Special Operations Command and Ft. Lewis-McChord, and I think a couple of the Marines, right? Have the Marines done it?

MR. CAIN: Yes, the Army at Joint Ft. Lewis-McChord and, then, also starting programs at Carson and Ft. Hood soon, and the Marines a little bit in the field.

MEMBER PHILLIPS: I was wondering,

next year or two years down the road, can that number be changed? Can that be flexible? Or does this have to go through the whole --

MR. DiGIOVANNI: The 180 days?

MEMBER PHILLIPS: -- the 180 days. If you find out that they really need 200 or 75 or --

MR. DiGIOVANNI: See, that actually resulted in a change to Title 10. So, if you want to look up the passage, it's -- and I've quoted it a lot -- it's Title 10, Section 1143, paragraph (e).

MEMBER MALEBRANCHE: Yes, it's legislative, sir. So, yes.

MR. DiGIOVANNI: So, you would have to change Title 10. I mean, it's possible, but when you talk to the Services, you know, a four-year enlistment potentially becomes a three-and-a-half-year one. So, I don't know what the temperature of the water is to increase it. My guess is it's probably going to stay at the six-month period.

These are some, you know, in an attempt to help the Commander have some vetted programs upfront, these types of resources are the kinds of things that we would expect the Service member and the Commander to talk about when the Service member would propose participating under this authority.

You can see the internship piece here at the bottom. So, that clearly falls into the sweet spot for what the unions want to do. I think another union organization we have talked to is the Teamsters. They have a similar program to the Pipefitters.

One other thing on this, anybody here from the VA? There should be, right?

DIRECTOR DAILEY: Sorry, we lost Ms. Malebranche to the briefing she had to give to Secretary Shinseki.

MR. DiGIOVANNI: Okay. So, I want to take just a second to talk about an opportunity we're working with the VA. So, we are working with their Innovation Department,

and they have sponsored digital training that was DARPA-based. It is called Education Dominance.

I think we have put about -- what is it? -- three cohorts of 20, Mr. Cain? What's the number? Somewhere in that area.

What they have been doing is the VA actually paid for veterans to come and go through 18 weeks of training in Palo Alto, California. It is in the IT sector. You didn't particularly have to have any IT background; in fact, they didn't want you to. You had medium-level ASVAB scores.

The three cohorts that have graduated averaged $70,000 salaries and one graduate got a $140,000 job with Amazon. And these guys had no tech background before they showed up.

So, we are looking at the potential to use the 1143(e) authorities to put people through that DARPA course in Palo Alto. So, I just throw it out as an

opportunity.

But the $140,000 graduate is a young man that is now basically digitizing one of Amazon's warehouses, and he is doing all the code with three other graduates. A pretty fantastic deal, and again, with no IT background before he went to an 18-week course. So, there are some great training opportunities out there, if we just simply leverage them.

This is an update from the chart that I showed you last year. I think it was 2011 data last year. This is 2012 data. This gives you an idea of the demographics that people are getting out of the military. This is who got out in 2012.

And you can see here we used the number around 250,000. You can see here about 273,000 people got out of the military in 2012.

I'm going to through these pretty quickly, but we did a licensing/credentialing

pilot mandated by law. You can see the statistics up here, about 3500 Service members. These are the pilots that we worked on on the left through the congressional program. And then, on the right are the pilots that we worked with the White House to work through.

If you notice, each of these areas where there is a nice confluence of civilian and military occupations.

Some of the pilot findings --

MEMBER DRACH: Sir, excuse me.

MR. DiGIOVANNI: Yes. Go ahead.

MEMBER DRACH: I went back to the previous slide, but there was very specific criteria, 180 days active duty and within 180 days of discharge. Is there any criteria for eligibility for the pilot?

MR. DiGIOVANNI: No. So, I changed gears on you just a little bit. This is a slightly -- in fact, it is a different initiative. It was required by Congress, and

what we are supposed to do is look at licensing or credentialing of Service members while they are still in the Service and, then, look at, is it more effective to do it while you're serving or is it more effective to do from an effectiveness and a cost perspective once you get out?

And so, I will tell you, in the Services I get mixed reaction when I say this, but I think there is an advantage to the Department to licensing and credentialing our people, not just when they are ready to get out, but throughout their entire life cycle.

Because, you know, we talk about the profession of arms and, yes, we have a very professional force, but I think it adds to our words about being professional if you can also show that you have met benchmarks in the civilian sector as far as the quality and level of competence of the people in the military.

So, what I normally say about this

is the licensing/credentialing thing is not limited to separating Service members. There actually is an advantage to the Department to seek civilian licensing and credentialing while you're still in the Service.

And the last point I will make on this, also, from a lot of procurements that we are doing, we are doing a lot of off-the-shelf types of procurements and buying things that are available in the civilian community. So, knowing more about how that stuff works I think also helps us.

MEMBER DRACH: So, then, there's really no criteria other than to have your MOC be compatible with one of the occupations?

MR. DiGIOVANNI: Yes. A couple of the criteria were, you know, we picked these because they were similar to the MOCs that we have in the military. There was the high probability of employment post-military services, and the salaries were somewhat commensurate to the salaries that our Service

members were getting.

We actually looked at three different pipelines:

Initial functional training. So, you went through your initial training to be a welder or a mechanic. And if you were able to at that time, go ahead and seek a certification or license.

Mid-career, once you have the necessary experience, five-seven years is what a lot of these required.

And then, that, actually, one-year to 18-month point, as you get ready to separate, to again look at an opportunity to get a licensing/credential.

So, we actually looked at three lines of action, at three different phases in one's career, for licensing or credentialing opportunities.

The key findings, nothing I don't think that is earth-shattering here. I mean, obviously, we do see that an opportunity to

get these credentials on a voluntary basis is desirable in gaining institutional support.

There are some barriers, and a lot of those barriers are really related to finance. For example, there are restrictions on use of tuition assistance to do these kinds of work because tuition assistance is mainly focused on higher education.

So, I think in this legislation they passed inflexibility and to be able to use TA, is that right? No?

MR. CAIN: No, we thought they were, but they did not.

MR. DiGIOVANNI: It didn't pass? But at least there was some consideration of doing that.

But a lot of it is it's going to be up to the individual to pay for the licensing and credentialing opportunity above and beyond what the military needs are. I think that's what No. 2 is getting at.

So, there were some pilot programs

to look at using TA. We will see where the Services go with that.

This Item No. 10 here is a little misleading. You know, that's essentially the cost of the credential to take the test. It doesn't address any gap training or education that might be necessary to actually to meet a prerequisite. It is just what it costs to take the test.

Sir?

MEMBER DRACH: If the Service member is eligible for the GI bill as a result of his or her active duty, will the VA pay for the credentialing cost? They used to. I don't know --

MR. DiGIOVANNI: I believe that the answer to that question is yes.

MR. CAIN: Thank you. The GI bill after 2010 will, in fact, pay for credentialing costs, but for every credential you take, you knock a month off your 37-months' benefit. So, a benefit is worth total

$2500-$3500, depending on where you are and where you go to school. For a credential, it may cost less than $500. So, it may not be a very good cost/benefit. But, right, technically, you can do that.

MEMBER DRACH: Let me just follow up on that. I don't know whether the 2010 legislation addressed this or not, but at one point in time -- think it was the Montgomery GI bill -- they would pay for the cost of the test, but they wouldn't pay for any costs associated with prep for the test.

MR. CAIN: I believe that is correct.

MEMBER DRACH: Okay. Thank you.

MR. DiGIOVANNI: Yes. And what Mr. Cain is getting at is that, to take one test, you would have to burn a month's worth of GI bill benefits. That is what he is getting at.

MEMBER MUSTION: So, is the Department of Defense taking on any action at

the national level with some of the national accrediting or credentialing agencies, unions, and other trade organizations to seek a waiver for a soldier, sailor, airman, and Marines to obtain credentialing?

Because what you have done is you have put the burden on the services to work their way through this. And I contend that at the national level this is something the Department of Defense --

MR. DiGIOVANNI: Yes.

MEMBER MUSTION: -- should be forging arrangements/agreements, MOUs of sorts, to recognize the program of instruction and certification that all members of the Department of Defense, depending on the specialty, have completed. Truck drivers, for example --

MR. DiGIOVANNI: So, are we on licensing/credentialing or are we on the job skills training?

MEMBER MUSTION: I'm talking about

licensing/credentialing.

MR. DiGIOVANNI: Yes. So, you're right. We have had dialogs with the VA for sure. This is one reason why I asked if we had someone from the VA here.

In the end, I will tell you that most of the burden is on the Service member because, when you look at the opportunities for paying for these things outside of military requirements, it is on the individual Service member.

I do think, well, I do think that, as we look at military compensation, your question becomes important. And I'll just leave it at that.

MEMBER DeJONG: I think I kind of understood what you said a little differently, sir, and let me try it with this. Why wouldn't the Department of Defense work with these certifying agencies, the Department of Transportation to get truck drivers a CDL license; the Department of Health and Human

Services to give medics paramedic licenses, EMT licenses? Why wouldn't they work with these at the national level --

MR. DiGIOVANNI: Okay.

MEMBER DeJONG: -- to ensure that this is done? Is that what you were --

MR. DiGIOVANNI: Okay. Okay, I got it. So, I've got good news there. And in fact, most of the licenses that we talk about are actually granted by states. There are federal licenses, but most of them are granted by states.

So, for example, in the last year, we will be -- what? -- in four months 100 percent complete, probably in that area. In four months, 100 percent of every state in the Union will offer a military Service member a military skills waiver to get a commercial driver's license. Every one of them have passed. And why? Because our office, in association with the Military Community and Family Policy, has actively worked with the

states to change legislation which allows them to do that.

And the First Lady challenged every Governor last year in February to get after the thing that you just said.

On the EMT and the medic issue, similar kinds of legislation. I don't think we're at the 100-percent mark, but --

MR. CAIN: Forty-six of the 50 states.

MR. DiGIOVANNI: Thank you. I knew it was right around 50 percent. So, about 50 percent of the states actually will give you credit for having experience or training in the medical area.

Now the other thing I'm working on is we made a promise, right? So, we have asked these states to change legislation to give military members credit. Well, we can't pull the rug out from underneath them because the next question is going to be, well, what is a 68 Whiskey and what does the POI look

like and how much experience and training and education do they get? And how much credit do they get?

So, I'm actually on contract, and we have been on contract now for about six months, to have a company build what I call a tech data package. Essentially, what it is is I looked at several -- and I'm focused on the medical profession, in particular -- I'm looking at several programs where community colleges have done a deep dive on programs of instructions in the medical field.

And that's at three different levels. So, your basic medic; your kind of independent-duty corpsman, and a special operator medic. And they understand what each of the training and education that comes with those four kind of POIs.

They have also developed a two-day competency-based exam. So, you can't always understand what somebody knows if you just look at what they got taught. So, then, they

put them through kind of a practical exam, two days. And at the end of that, they custom design a program for you if you want to be a paramedic, if you want to be an RN, if you want to be an LPN, whatever it is that you want to do.

So, what I'm doing is I'm taking -- there are three schools that have done it, Tulane, Lance Community College, and Texas A&M. So, I'm having this guy go out there and look at all three of those programs and, then, build a technical package that says here's the decoder ring and here's three schools that have already done it that are accredited.

So that, when someone asks, "Well, what did this person do," I go, "Look, here's the tech data package. You can kind of find that individual, you know, look up their qualifications in here, and that will at least give you some idea of how much credit you should award them."

The other thing that I think they

absolutely have to do is they've got to look at a competency-based exam. You know, if you're really going to do this, what you learn on a combat battlefield is not written down anywhere, but you probably have some skills that you may not take credit for unless somebody asks you to do something.

So, we're going to encourage them to look at competency-based skills exams when they look at awarding a license or credit toward a license for a military Service member.

So, I think those are probably the two main thrusts. The other one we're looking at is in the law enforcement area. So, we are working with the National Governors Association because the states also have accrediting for police officer training and they have reciprocal agreements or reciprocity agreements with other states. So, we are looking at those three areas right now.

MEMBER DRACH: And I go back just

a couple of steps --

MR. DiGIOVANNI: Yes, sir.

MEMBER DRACH: -- to the earlier, the apprenticeship program. Are you doing anything to reach out to make this information available to those wounded, ill, and injured that are assigned to a WTU?

MR. DiGIOVANNI: Yes. So, probably not as active because my area is in training, and I'm mostly focused on Service members.

What I have done is, for example, in SOCOM I have a very good relationship with the Care Coalition Director. And on the DARPA program I talked about, I have actually said, "Look, let's look at opportunities to put some of those folks in, either using the 1143(e) authorities or, if you're already out, use your Voc Rehab capability to pay for that 18 weeks of training.

So, I have, initially, in the last two weeks, I have opened up a dialog with the

WTUs, with the Reserve folks, and, also, I have had one with the Care Coalition for about 18 months. So, that's kind of where I'm at on that. I'm probably not as far as I would like to be, but we're starting to coalesce.

MEMBER REHBEIN: Sir, in some of the skilled trades -- and welding is one of them; I see that as a White House pilot -- a certified welder is certified by the employer. And so, if that welder changes jobs, he has to recertify.

That presumes that, then, before you came become a certified welder, you have to be employed as a welder. PWS handles those things. Is there any work to try to get a certification for the military person?

MR. DiGIOVANNI: Let me see if I can answer, and then, I'll get Mr. Cain on it. So, what we have done is we have got, I think it is the schoolhouse at Ft. Pickett, right?

MR. CAIN: Ft. Lee.

MR. DiGIOVANNI: Ft. Lee.

So, we've actually got military instructors, third-party certified, to give the welding exam to graduates. So, that kind of helps them navigate that system because they have been certified by the American Welding Society to give that exam. And by the way, that affects Army and Marines.

And so, we have looked at a way to do that, so that you don't have to be employed, that we have actually got instructors that are military that are certified to do that.

I talked to some folks up in Canada that are working the oilfields. And they don't care if you're certified or not. They told me, they said, "Look, you can come with all the certifications in the world, but we are going to give you a competency exam. So, we're going to tell you to do three types of welds. And if you pass those welds, you get a job."

So, it is kind of what you said.

In some cases, people are going to want to do that anyway because of the liability associated with that kind of work.

But I think the third-party thing answers your question, your concern.

MEMBER PHILLIPS: I'm curious about potential pushback from an employer. For example, if someone goes through the DARPA skilled program, and before they leave active duty they come back and say, "Well, I have a new skill. I want to stay in and be in Cyber Command," does that happen? Because the employers are putting time and effort into this.

MR. DiGIOVANNI: We haven't had anybody go through the DARPA course, for example, on the IT side. They have all been vets.

I think you have to already have filed for separation, which means that the only way you could actually come back is the military would have to say, "Okay, let's tear

up your separation papers." And they might, and there is some liability there.

I would think that would be something you would want to talk about if you did an MOA with somebody to say, "Look, we're not going to let you train these people for free and, then, steal them back." I mean, we probably should say, no, if they go into this program, they're getting out. But that is an interesting thing, and I will keep that in mind.

I'll tell you, there is some concern with this program on the other side, which is we go around and tell people that we've got this opportunity, and then, Commanders don't take advantage of it, right? So, I don't want to overpromise, either.

This program is very new, which is why we need to collect data on it to say, "Well, our Command is actually releasing people to go do these programs," or not.

MEMBER DeJONG: I think you're

going to have a hard time with that.

MR. DiGIOVANNI: I think there are concerns there as well. I think your comment -- which is why I mentioned it, because I do want to make sure that I don't overpromise the program.

MEMBER MUSTION: I don't think so they can take issue with it, at least on the active side, for the next three to five years because we're going from 525-528 in the Army active side down. Early-out authorities that were recently received approval of to let soldiers out of the Army after 360 days or 265 days early.

In the readiness path we're on, I think the challenge that we will have is finding enough opportunities for these internship programs or our apprenticeship programs and credentialing programs. So that we can facilitate a smooth transition for soldiers and others from the other Services out of the military and into the civilian

world, the civilian sector.

MEMBER DeJONG: No, I understand that.

MEMBER MUSTION: I think the model that we had at JBLM and what that union was able to work is a great example, but that is an isolated pocket of success of 20 or so soldiers. So, how do you proliferate that across the United States?

MR. DiGIOVANNI: Yes, sir.

MEMBER DRACH: So, your current slide says, "Key pilot program findings". Does that mean that there is a full-blown report? And if so, can it be shared?

MR. DiGIOVANNI: That report, I don't think it's posted publicly. Or is it now public?

MR. CAIN: It's available to the public. I mean, we didn't post it on the website.

MR. DiGIOVANNI: Yes.

MR. CAIN: But it has been

released to Congress.

MR. DiGIOVANNI: Yes. So, if you would like a copy of it, please let me know and we'll get you a copy of it.

MR. CAIN: I'll send David a copy.

MR. DiGIOVANNI: But it was open. We sent it to Congress, so it is an open report.

But it's focused on that licensing/credentialing pilot, and not on the 1143(e) stuff, just to be sure I manage the expectations. Okay?

So, I'm rolling this out. This will be the first time it has been rolled out publicly.

This is an app that we're working on. Mr. Vollrath named it Skillbridge. And just what it sounds like, what it is, it's an app that will be used by both employers and the Service member to link them to job training opportunities while they are still in the military.

So, we are hoping to use the Transition GPS and word of mouth to ask people, to say, "Look, if you're interested in these job training opportunities, then this app is one way that employers can connect to you."

I don't think there's another slide here. No.

So, what this thing has is it uses tweets. It is a Twitter-based app. There's a specific format you have to follow.

And really, the vision here was to kind of look, what's the 21st century version of a classified ad for a job training opportunity. So, a tweet is actually about right when you look at brevity of characters and communicating a maximum amount of information in a little bit of space.

And so, if you look at the demographs that we were trying to communicate with, they're not going to read a War and Peace document. But a tweet that you get a

notification on on your mobile device that says, "Hey, the Ft. Lewis-McChord guys are going to kick off their next welding course, and it's going to be in three weeks. If you're interested, here's the URL link to link to their site to sign up for it." That's kind of how it is going to work.

So, employers can go into this thing and provide job training announcements. You sign up for hashtags. So, look, I'm not a big Twitter guy, but I'm just going to -- and you're laughing, as you should -- I'm not a big Twitter guy, but my vision is to divide the job training categories by hashtag.

So, if you're interested in being a commercial drive or if you're interested in being a welder, if you're interested in the construction business, then you can sign up to get tweets about job training opportunities categorized by hashtag. Okay? So, everybody got me on that?

MEMBER DeJONG: Just to clarify,

I'm not laughing at you; I'm laughing with you.

MR. DiGIOVANNI: There you go. I do tell people that I am a digital immigrant. I do tell them that. I am a digital aborigine. So, I was here before they had Twitter.

But I think this is an excellent opportunity. I mean, many of you have heard this, but over and over again industry says, "How do I talk to the Service member before they get out? How do I do that?"

You're not going to get everybody on the base. There isn't time nor facilities to do that. But, if you can reach out to them virtually via a tweet, then you've just opened up some great opportunities for our Service members and for industry that are looking to hire Service members, to notify them of job training opportunities.

And I do advanced distributed learning for the whole federal government.

So, that was actually a built in-house level of effort. So, no cost there. I just reprioritized what they were doing.

But that's about ready to get rolled out. In fact, if any of you would like to help me prototype it, I'm looking for some people to help me prototype it. I don't have it.

We're also talking about whether or not we're put it -- you know, when I say, "Put it out in the wild," what I mean is that you could go to the Apple store and download or you can go to the Android store and download it. Or, if it is going to be something that's in-house, you have to go to a website and download. We're still looking at it. But I'm more likely to try to put it out in the wild where it is more accessible. That is kind of where we're going with that.

And then, I think this next one was just the last slide, and I think I've covered everything.

Questions?

DIRECTOR DAILEY: Real quick, Mr. DiGiovanni, that particular Skillbridge, is it going to be advertised also through the GPS Transition classes? Okay. So, that's --

MR. DiGIOVANNI: So, a strategic partnership with Dr. Susan Kelly --

DIRECTOR DAILEY: Okay. Good. We know Dr. Kelly, yes.

MR. DiGIOVANNI: to make sure, and we have been working with her very closely through the entire development period.

DIRECTOR DAILEY: Yes, yes.

MR. DiGIOVANNI: Because, otherwise, it's word of mouth.

DIRECTOR DAILEY: Sure.

MR. DiGIOVANNI: The only way to get it out to Service members is by word of mouth.

DIRECTOR DAILEY: Right. Good. So, GPS Transition programs will be passing out that information on how to link into

Skillbridge?

MR. DiGIOVANNI: Yes.

DIRECTOR DAILEY: Because, as you noted, 273,000 people left the military last year.

MR. DiGIOVANNI: Yes.

DIRECTOR DAILEY: Theoretically, they're all supposed to be going through GPS Transition programs.

MR. DiGIOVANNI: Yes.

DIRECTOR DAILEY: And theoretically, you would, then, be delivering that to all 270,000 departing individuals.

MR. DiGIOVANNI: Yes.

DIRECTOR DAILEY: That would be not a bad marketing effort annually.

Okay. So, good. Thank you.

MR. DiGIOVANNI: One other quick thing on that that I would tell you will help us is, right now, we're looking at having a very small interface. In other words, we don't want just anybody putting their job

training opportunity up there because they could have malicious intent, or just whatever.

So, there will be a small filter that says, "Look, if you want to post here, then there's a small vetting process."

The other thing that does is it allows us to look at statistics. So, how many people are using the website? How many people are actually responding to a tweet? How many people have signed up to give us jobs?

So, we think that collecting statistics on that will help us understand if these kinds of programs are going to be really effective.

MEMBER DeJONG: Sir, have you reached out to any of the major employment agencies, CareerBuilder, Monster, anybody like that? Because I know particularly CareerBuilder was building an MOS tool similar to what you were talking about that actually broke it down as far as the ASVAB score to look at fine technical -- more than just a GT

score like they normally use in the Army.

So, in lack of duplicating efforts like we do so well, have you reached out to them and seen what --

MR. DiGIOVANNI: In fact, I've talked to Monster.com a couple of times. And Heroes to Hired also has a very -- in fact, they told me, they said, "Look, you know, don't waste your time building one of those crosswalk things. What we have in that program is really, really good."

This thing is kind of niche in that my purpose for doing it is job-skills-training-focused only. And it's for while you're still in the military. Now, when you get out, can you still use it? Yes, I'm not going to -- I don't think we should try to filter that. But it is focused on a very niche thing. It's getting the people to sign up to use it and, also, getting the industry to post things there.

MEMBER DeJONG: And I guess

further to go with that, that might be a way to reach out to industry to come back. Those agencies know who is looking for work. They also know the skills. But they are also for-profits. So, you've got to play the --

MR. DiGIOVANNI: You're right, which is why that 1143(e), the lawyers took some time before they put the caveats in there that they did, because they were worried about just those kinds of things that you just said.

MEMBER DRACH: A couple of things. I just want to throw this out without a recommendation.

MR. DiGIOVANNI: Sure.

MEMBER DRACH: Are you aware of DirectEmployers, based in Indianapolis?

MR. DiGIOVANNI: I'm not, sir.

MEMBER DRACH: Okay. It's something to think about, kind of building on what the Command Sergeant Major just said about reaching out. I need to think whether that is a good conduit or not.

I may be mixing apples and oranges in this next comment or question, but they're both in the same bucket. I know your program is statutory, your pilot.

MR. DiGIOVANNI: Uh-hum.

MEMBER DRACH: I don't know whether the one that NGA is doing with the Department of Labor and the six-state pilot, whether that is statutory or not.

MR. DiGIOVANNI: It is statutory. It is driven by the VOW Act.

MEMBER DRACH: That's what I thought.

And you mentioned doing work with NGA. Have you all compared notes and the like --

MR. DiGIOVANNI: Yes, absolutely.

MEMBER DRACH: -- at the beginning?

MR. DiGIOVANNI: Yes. We have been --

DIRECTOR DAILEY: Okay. Hold on.

NGA is --

MR. DiGIOVANNI: National Governors Association.

DIRECTOR DAILEY: Thank you.

MR. DiGIOVANNI: Sorry.

We have been a partner from the very beginning with the Department of Labor and the National Governors Association. And that NGA partnership was competed by the Department of Labor, and that's who won the competition.

MEMBER DRACH: Did you have any input or wish you had had input into the six states that they identified for the pilots?

MR. DiGIOVANNI: We did. Not only did we have input in the states, but we also had inputs in the occupational focus. In fact, I believe that the law enforcement focus came from us. They looked and said, "Hey, we want to do medical; we want to do truck drivers. What else can we do?" And we settled on police.

MEMBER DRACH: So, you have submitted your report to Congress. Do you know whether or not NGA has submitted their report?

MR. DiGIOVANNI: That report is still ongoing. When is that report due, Mr. Cain?

MR. CAIN: The states are working the details now.

MR. DiGIOVANNI: Just tell me what it is, and I'll repeat it.

MR. CAIN: Early 2015.

MR. DiGIOVANNI: Early 2015 for the report from the Department of Labor and NGA.

MEMBER DRACH: Thank you.

MR. DiGIOVANNI: Anything else?

DIRECTOR DAILEY: We were just down talking with Kevin McDonnell and his team. We gathered many of the same products that he has provided you, and we were going to put them in the report as opportunities for

the Services to use them as templates. Obviously, you have already done that in your DODI. Thank you very much.

MR. DiGIOVANNI: Uh-hum.

DIRECTOR DAILEY: Mr. McDonnell and SOCOM have also been very, very strongly advocating their program for intelligence-based job hunting. Can you give me what you thought of that program and their advocacy for this type --

CO-CHAIR CROCKETT-JONES: Crossroads or Soft Crossroads.

MR. DiGIOVANNI: Yes, the good thing is I don't know the company.

DIRECTOR DAILEY: Good.

MR. DiGIOVANNI: So, that's good. I did see a demo of it and I talked to them about -- actually, I think I talked to them last week about it.

So, I think there is an area where that could be useful because a lot of the systems that we have now that do job searches

or they do resume searches, it is a pure word search kind of thing. And so, you really do need to have some kind of artificial intelligence that understands that, if you say, you know, that you're -- I don't know. He showed an example. It had to do with something in intelligence, that you knew that intelligence has multiple other kinds of meanings. Because a lot of these word search things, if you don't find the specific word, then you get kicked out.

So, it helps both companies to look at resumes to see, well, what I really wanted was a security analyst that was focused on counterespionage. Okay. So, you put in counterespionage. And then, if you don't find the word "espionage," then you get kicked out. But if it has intelligence, it knows that, oh, well, maybe if you have intelligence background, you probably have some espionage background. So, let's give them that. Let's give them that resume.

So, I think there is a lot of capability out there. There are other things besides what SOCOM is pursuing in that area. I mean, in the end, it still is a rule-based AI, artificial intelligence. So, it is not perfect.

But I do think that there is some ground to be gained by looking at innovations like that to make better matches.

Anything else?

(No response.)

All right. Boy, I got off a lot easier this time than I did the last time.

(Laughter.)

DIRECTOR DAILEY: Thank you, Mr. DiGiovanni.

MR. DiGIOVANNI: You're welcome. Thank you.

DIRECTOR DAILEY: And we're very appreciative of your efforts to get this DODI published. We have been tracking it for a while. Anyone who can get a DODI published

who has taken on the Services with as much pushback as we know you got and said, "We're going to do this anyway," is a hero for us.

MR. DiGIOVANNI: Thank you.

DIRECTOR DAILEY: Thank you.

CO-CHAIR CROCKETT-JONES: Absolutely. It must be nice, you didn't have to bury the lead. You could just give us the answer we were bugging you for last time. It must have been a little less --

MR. DiGIOVANNI: Well, I knew you would ask me again.

CO-CHAIR CROCKETT-JONES: Absolutely.

Thank you very much.

MR. DiGIOVANNI: You're welcome. Thank you very much for what you do.

CO-CHAIR CROCKETT-JONES: We'll take a 10-minute break and come back in time for our next briefing.

(Whereupon, the foregoing matter went off the record at 1:48 p.m. and went back

on the record at 2:00 p.m.)

CO-CHAIR CROCKETT-JONES: Okay, we now welcome representatives from TRICARE Management Activity, Health Net Federal Services, and United Healthcare, who will brief the Task Force on programs and processes for Recovering Warriors through Health Net and United Healthcare.

On the phone, we have joining us Ms. Patricia Reilly, a nurse consultant from the TRICARE Regional Office West, as well as Ms. Sheri Erickson, Ms. Teresa Pierce, Ms. Yvonne Harrington, who are representatives from United Healthcare. In person, we also have Ms. Brandi Barnette, a nurse consultant with TRICARE Regional Office North, and Ms. Eileen Yeager, the National Capital Region Director of Medical Management for Health Net Federal Services. The members can find this information under their tab M.

I'm going to turn this over to Ms. Barnette and Ms. Yeager.

MS. BARNETTE: Thank you. Good afternoon, Task Force Members.

I'm going to apologize in advance for my voice. I am getting over laryngitis.

I would like to thank you all for the opportunity to talk to you about how the purchase care system also supports our Recovering Warriors.

And I work at TRICARE Regional Office North. And so, Health Net Federal Services is our Managed Care Support Contractor. I am going to talk about their program, which is the Warrior Care Support Program.

Okay. The Warrior Care Support Program provides individualized care coordination and transition planning to active-duty Service members in any of the uniformed Services, including Reserve component and National Guard members with active-duty status who are severely injured or ill and who meet the Warrior Care Support

Program diagnosis criteria, which we will cover in a later slide.

The collaboration between the Managed Care Support Contractor, which is Health Net, and the government includes collaboration with the NTF staff as well as the Warrior Transition Unit staff, case managers.

The role of the case manager for the Warrior Care Support, who are known as Healthcare Coordinators, they serve as a single point of contact for the warrior and their families or for the NTF or WTU case managers for all the civilian care coordination.

Okay. The Warrior Care Support Program was established in August of 2007. Since inception, there have been 5,887 Service members that have been enrolled. There are currently 319 Service members receiving services at this time.

And then next slide reviews the

demographics, with the Army having the highest number of enrollees, followed by the Marine Corps, and then, the other Services.

We had a question regarding customer satisfaction. At this time --

DIRECTOR DAILEY: Hang on. Hang on just a minute. I apologize.

MS. BARNETTE: Yes.

DIRECTOR DAILEY: We do have some puzzled looks among my members. So, let me see if I can clarify.

So, at the TRICARE Management Agency level, there are some dedicated resources that -- and I'll use this -- MCSC, this is the Military --

MS. BARNETTE: The Managed Care Support Contractor.

DIRECTOR DAILEY: Okay. This is the Managed Care Support Contract. And so, these are TRICARE Management Agency and contractor resources that are dedicated to facilitating the civilian care piece for

wounded, ill, and injured and that categorized as wounded, ill, and injured?

MS. BARNETTE: Yes, ma'am.

DIRECTOR DAILEY: Okay? Are we all clear now? This is not MTF. This is not a nurse case manager in an MTF. This is TRICARE Management Agency and contractor resources facilitating civilian care services.

Okay. You may proceed.

CO-CHAIR CROCKETT-JONES: Can I ask, is the IC3 the lead coordinator and aware of and is this part of their --

DIRECTOR DAILEY: That might be one of my questions. It might be one of the questions.

CO-CHAIR CROCKETT-JONES: I'll be patient. Okay.

MS. BARNETTE: It is not one of the questions that we were supplied.

DIRECTOR DAILEY: Well, let us get there, then.

MS. BARNETTE: Okay.

DIRECTOR DAILEY: I need everyone to get the same knowledge base, understand the A's, B's, C's, and then, we'll get to more sophisticated questions.

MS. BARNETTE: Okay. Okay, so customer satisfaction, at this time surveys by the Managed Care Support Contractors are prohibited by the DHA, but they have received positive feedback thus far regarding their program.

And the next slide covers the diagnosis criteria that will allow access into the program. They have to be severely ill or injured and, as you see above, the following diagnoses will grant them access into the program as far as the purchased care side. Reserve components are eligible as well, as long as they show eligible in DEERS.

MEMBER EUDY: So, if they happen to fall out of DEERS on the Reserve component side, do they, then, have to be re-placed in there? Or do they stay in the program as long

as they have been inputted initially?

MS. BARNETTE: Ms. Yeager, I'll let you answer.

MS. YEAGER: They have to be TRICARE-eligible. It's a TRICARE program.

DIRECTOR DAILEY: So, if fall out of DEERS, they have fallen out of TRICARE, and they have to go through the process of re-enrolling. So, yes.

MS. BARNETTE: Okay. As far as referrals, referrals are received from the NTF, from the VA. And Health Net has an internal medical management system that is based on the diagnosis codes that will also refer wounded, ill, and injured into their program.

CO-CHAIR CROCKETT-JONES: Okay, but here's one of my questions: the diagnoses that you list, though, we have huge numbers with some of those diagnoses. Is there a further criteria that triggers enrollment? Because your enrollment numbers versus those

who have been, say, separated due to TBI and PTSD, medically retired, you know, those numbers are pretty large.

I'm wondering if there is some secondary -- put it this way: how do you assess that someone is severe enough to be in your program beyond those diagnoses?

MS. BARNETTE: Would you like to --

MS. YEAGER: I'll give that a stab.

The criteria for selection, these are Service members who are getting care in the civilian network. So, that takes a lot of them out.

CO-CHAIR CROCKETT-JONES: Okay.

MS. YEAGER: When we receive a care request for any kind of civilian care, it is an active-duty Service member and they are primarily injury codes and for behavioral health, Post Traumatic Stress Disorder. It triggers an automatic referral.

And we will follow them as long as they are receiving civilian care until they either do not want to be engaged in the program or they return to full duty or they are medically retired. If they still have needs at that time, we will transition them to our traditional case management program.

MEMBER MUSTION: So, if I could maybe a question from a little bit different angle? At a couple of installations that we have been to, we were told that a number of soldiers that are in our WTCs or WTUs at some installations are being referred into the network to receive care, principally behavioral healthcare at one particular installation.

So, would those soldiers be part of this program?

MS. YEAGER: Yes.

MEMBER MUSTION: I mean, I can't give you a specific name or those sorts of things, but --

MS. YEAGER: Yes, yes. For behavioral health, we are focused on Post Traumatic Stress Disorder diagnosis. When we receive a referral, we contact the case manager at the military treatment facility or if they are in a WTU, and we collaborate to determine who is going to follow the case. Sometimes we do that together. Sometimes we are told, "We're doing okay by ourselves." Most of the time, we enroll them in our program and work collaboratively with the direct-care system.

MS. BARNETTE: Okay. Which is a nice segue into our next slide, which is assisting with psychological needs. They do have Behavioral Health Coordinators that work with the Recovering Warriors with PTSD, as Ms. Yeager stated.

They do screening services to include the PHQ-2 Depression Screening and the PTSD screening, which is also used by the VA; communicate the findings to the PCM and

coordinate/collaborate with direct care with the civilian and the VA providers and offer transition planning, which she covered.

Okay. In reference to care coordination and case management, the focus is on coordinating the civilian care, the purchased care, with the direct-care system on behalf of the Recovering Warrior, and to also support transition from active-duty status.

Through Health Net, they are able to monitor all civilian care and anticipate the coordination needs at the time of separation and collaborate with all involved parties, NTF, VA, and other entities, in coordinating the care.

MEMBER DeJONG: Can I ask a quick question? And this may be self-explanatory, but I'm trying to see if I'm interpreting it right.

What types of conditions would the VA refer an individual to? Is it just something that the VA facility itself can't

handle? I'm kind of lost at where the VA would refer someone to outside care. And could you further explain that to me and how, or give me an example of how that would work?

MS. YEAGER: Would you like to answer?

DIRECTOR DAILEY: Well, so when someone is going to the VA under their TRICARE benefits --

MEMBER DeJONG: Right.

DIRECTOR DAILEY: -- they're getting TRICARE, and VA doesn't have an MRI at that facility.

MEMBER DeJONG: Okay. That's what I thought.

DIRECTOR DAILEY: Okay.

MEMBER DeJONG: I just wondered. Okay. But that's what I thought and I just wanted to clarify that.

DIRECTOR DAILEY: Now, reality --

MS. YEAGER: Generally, in this program these are folks who are still active-

duty. So, they haven't transitioned to the VA. But it would be very similar.

A good example would be someone who is being discharged from a military hospital and needs home healthcare, and they don't have home healthcare as part of the direct-care system. So, they would send an authorization to us, to Health Net, to arrange for and authorize home healthcare.

MEMBER DeJONG: Okay. That makes sense. Thank you.

MS. BARNETTE: And that is all of the briefing. I'll open it now to any other questions.

MEMBER REHBEIN: When you talk about the screenings, the psychological needs, let me make sure I understand correctly. You're talking on that slide about people that already have a PTSD diagnosis, correct? I guess I'm wondering what the additional screening does.

MS. YEAGER: We would be doing

that screening on Service members who came to us for another diagnosis. So, perhaps they came with a trauma diagnosis or a burn. We would do the Post Traumatic Stress Disorder screening with them.

DIRECTOR DAILEY: Okay. So, when you say, "We would do...," you mean that you would authorize the provider --

MS. YEAGER: No, we would actually --

DIRECTOR DAILEY: Who's "we"? Who's "we"?

MS. YEAGER: Okay. We have nurses and social workers who serve in the role of Warrior Care Support Coordinators with Health Net Federal Services.

DIRECTOR DAILEY: Okay. Some way or another, I'm not getting you in that speaker. I'm not hearing you.

MS. YEAGER: Oh, okay. Is that better?

DIRECTOR DAILEY: There you go.

Much better.

MS. YEAGER: My fault.

Okay. We have clinicians who are working in the role of Warrior Care Support Coordinator. They are primarily nurses. We have some social workers doing behavioral health.

And they would, when they worked with the Service member around their care coordination, they would be administering the Post Traumatic Stress Disorder screening tool with the consent of the vet, of the Service member.

So, if they are already coming to us with that diagnosis, we wouldn't be looking for it. These would be folks with physical health diagnoses.

DIRECTOR DAILEY: Okay.

MS. YEAGER: So, we just want to identify who hasn't been identified.

DIRECTOR DAILEY: Okay.

MEMBER REHBEIN: So, you get a

nurse face-to-face with everyone that's referred into your system?

MS. YEAGER: It's telephonic.

MEMBER REHBEIN: It's telephonic?

MS. YEAGER: It's telephonic, yes.

DIRECTOR DAILEY: All right. So, there is no office space that you have set up where they're coming to you for a service?

MS. YEAGER: No. No.

DIRECTOR DAILEY: Okay. So, these screenings are telephonic?

MS. YEAGER: Correct.

DIRECTOR DAILEY: And it's not a referral. It is being delivered by your services?

MS. YEAGER: Correct.

DIRECTOR DAILEY: Okay.

MEMBER REHBEIN: And it's looking for additional conditions?

MS. YEAGER: Yes. It's trying to identify anyone who may have gone undetected. And then, we just report that. We have a

conversation with the primary care manager and let them take it over. We are not treating people.

CO-CHAIR CROCKETT-JONES: So, what are your caseloads like? You have 319 current Service members receiving these services. How many folks do you have for those 319?

MS. YEAGER: We have six, six people. Now we have levels in the program. When we started the program, we wanted to be very careful that we didn't duplicate or create too many people for the Service members to deal with because many of them are engaged with case management in the direct-care system.

So, when we get a referral -- and I think I mentioned that earlier -- the first thing we do is we get to the military treatment facility case management team and say, "We can be the primary on this, if you want. But you're leading it. We'll be primary for you."

So that, if the case manager, say, at Walter Reed is managing, you know, say they have 40 people, and they need to know something about a Service member, they don't have to call all over Health Net. They have one dedicated person who's taking care of all of their civilian care coordination on their side. So, they team it. So, that allows for a slightly-bigger caseload.

CO-CHAIR CROCKETT-JONES: So, a portion of your 319, your contact is primarily with another case manager --

MS. YEAGER: Correct.

CO-CHAIR CROCKETT-JONES: That's a portion --

MS. YEAGER: Correct.

CO-CHAIR CROCKETT-JONES: Okay.

MEMBER PHILLIPS: When you have someone being cared for through your contract, MCSC, are you having difficulties? Are you getting any followup as far as the medical information being sent back to their primary

care or any issues with that, if they go out for a test or they go out for consultation?

MS. YEAGER: Not that have been identified. That hasn't been an issue for us. I can't speak necessarily to the direct-care system because we're not receiving that information.

MEMBER PHILLIPS: Yes, I would guess there may be some difficulties, but you're not aware of them?

MS. YEAGER: You're talking about like when a primary care manager sends someone outside for a specialty visit? Yes, there are requirements are that.

In the previous contract, we were involved in that paper chase, but now the Military Treatment Facilities are handling that on their own.

CO-CHAIR CROCKETT-JONES: Any other questions?

DIRECTOR DAILEY: So, this system is embedded now in all three Regions, West,

North, and --

MS. YEAGER: South.

DIRECTOR DAILEY: -- South? Is that a correct statement?

MS. BARNETTE: That is correct.

DIRECTOR DAILEY: Okay. So, we first heard about it in San Antonio. And so, on the line we have North and West, because we initially heard about it in the South, TRICARE Region South or the contract South.

Do all three Regions -- so, this number that you have here is for all Regions? Okay. All right.

MS. BARNETTE: No, ma'am. It's just the North.

DIRECTOR DAILEY: This is only for the North? Okay. So, this information is only for the North?

CO-CHAIR CROCKETT-JONES: So, that 319 number of current -- is that only for the North or is that programwide?

MS. BARNETTE: That is only for

the North.

CO-CHAIR CROCKETT-JONES: Okay, and a followup on that IC3, the Lead Coordinator Working Group that is working between both the DoD and VA agencies, have they talked to you or gotten input? Is there any communication going on there?

MS. BARNETTE: Not to date, but I am going to be included in the IC3 group and will be participating in the meetings.

CO-CHAIR CROCKETT-JONES: Also, is this part of case management training or RCC training? Do you know if the folks that bring that, if this is -- they're either --

MEMBER EUDY: This was touched on, but very briefly. It is more designated towards Service-specific, that it would be something that would be even in-depth after the RCC course. To what level of depth, I'm unsure at this time, but I'm willing to bet that, amongst the RCC community, the knowledge is very low, as a lot of this is coming out.

DIRECTOR DAILEY: Actually, I have an RCC in the room who's going, "Never heard of it." But, okay, I get it. And that's why we wanted to get it out on the table really.

I mean, when we were in San Antonio in Texas in September, we realized there was another level of case management being executed at the TMA Regional level, and we wanted to understand it better.

And so, this briefing right here is only from North. If you'll flip a couple of pages, you'll see the West briefing. I've got the West guys on the line here, and they're going to go through the same set of slides for you.

CO-CHAIR CROCKETT-JONES: Okay. Let's have them do --

DIRECTOR DAILEY: Good. So, we did have South come in and brief us while we were in San Antonio. I know it was a long time ago and some of you weren't here. So, you're not connecting all the dots, and that's

okay. I'm expecting a lot.

But we had the South at San Antonio. We just finished the North and their caseload and their clients. And I've got West on the line, and we are going to turn it over to them.

MS. REILLY: Good afternoon, everyone. This is Trish Reilly, the nurse consultant at TRO West. Can you all hear me okay?

DIRECTOR DAILEY: You're good.

MS. REILLY: Okay. Great.

Thank you again for inviting myself and my colleagues at United to be able to brief you about the program that United provides to the active-duty Service members and, in particular, the Recovering Warriors.

So, I'm on slide 2. That is a component of Department of Healthcare Agency. We have just changed our agency recently, as of October.

And this is the DHA vision: "A

joint, integrated, premiere system of health supporting those who serve in the defense of our country." And so, we are part of the military healthcare system.

So, during this brief, what I'll be doing is I will introduce you to my colleagues who are also on the phone. We are all in separate locations. So, bear with us.

A brief overview of United and the relationship with the contract that we affectionately refer to as "T3," TRICARE 3; the programs and points of contact, and any questions.

So, to start with, I'm on slide No. 4.

On the phone with me is Shari Erickson, who is the Vice President of Medical Management at United Healthcare Military and Veterans. We also have Terry Pierce, retired Colonel, U.S. Army nurse, who is the Director of Military Programs, and Yvonne Harrington, who also is a former active-duty Army nurse

who served in Iraq. And she is the Warrior Advocate Case Manager. And United refers to their specific program as the Warrior Advocate Program.

Next slide.

I think this overview might help give a little perspective of the current contract, the different contractors, TRICARE in general, and I think there might have been a little bit of confusion earlier for some of the members.

So, the TRICARE contracts are divided into three Regions, and they had to do that because of the vast size of the United States. So, there is, now you know, the TRICARE Regional Office North, South, and we're in the West. And we have a big chunk geographically of the country, though much of it is rural. We have Hawaii and Alaska as well.

So, United Healthcare Military and Veterans is the Managed Care Support

Contractor for the West Region, Health Net in the North, and Humana has the South.

United Healthcare Military and Veterans didn't get started with this contract, this current contract, until April 1st of 2013 because there were protests related to the contract.

So, to give you some perspective, TRO North and Health Net started first on April 1st, 2011, followed by the South; the next year, April 1st, 2012, now United. Both Health Net and Humana were incumbents and already had the previous TRICARE contract. United Healthcare is brand-new to this TRICARE business. And so, we are less than a year into this contract.

Next slide, please.

The difference on this contract, the current T3, TRICARE 3, contract, and "3" relates that there was an initial contract many years ago. Then, we did Tnext, the next generation. And now, we're on the third

version of the contract.

And there was a change in the language in that contract that now provides that the Managed Care Support Contractor can provide case management and coordinate with the MTF clinical staff and civilian providers for active-duty Service members whose care is projected to occur in full or in part in the civilian sector.

So now, active-duty Service members have access to United general and specialized case management programs. Those include the cancer clinical trials, cancer support, community case management, integrated case management, transplant, and the Warrior Advocate Program.

Now community and integrated case management programs can include a blend of both medical/surgical case management and behavioral health case management. So, you can have a combination of both types of case managers involved in the case at United. You

may have one predominating over the other, a balance of both. There's always just one case manager who is the primary case manager.

The Warrior Advocate Program -- next slide, please -- did get started April 1st, 2013, when the start of healthcare delivery began in the West Region. It now supports the current TRICARE contract, which includes that language that allows the contractor to work with the Military Treatment Facilities, or MTFs, as we call them, and whose care will be in part or in whole out in the network.

The current contract did not specifically require that the contractor, the Managed Care Support Contractor, have a separate, unique Wounded Warrior or Warrior Advocate, you know, type program. What it did say, though, is you will work with the MTFs as well as with other case management entities in the military healthcare system to help coordinate and corroborate for active-duty

Service members.

So, United developed this specialized program that they call the Warrior Advocate Program in response to that language and, also, recognizing that there was a need for a specific program, due to the unique and complex issues that face the Wounded Warrior population.

Next slide.

So, this program is led by Yvonne Harrington, who I introduced you to on the phone, who spent seven-and-a-half years on active duty with the Army. So, she has been also deployed to Iraq herself. So, she is not only an advocate for the Service members having served, but also, I think, understanding the issues that the deployed Service members face uniquely, and as well as Terry Pierce is a valuable asset to us because of her expertise with the Army Nurse Corps.

So, her responsibilities include coordinating with the MTF clinical and case

management staff, the civilian providers; in addition, all of the other non-medical and medical case managers that may be involved with an active-duty Service member's care, including CBWTUs, WTUs, VA providers and case managers, RCCs, and FRCs.

The focus is on identifying the specific needs of the Recovering Warrior and to provide an integrated case management program to meet that Service member's needs. And they look at this as more of a holistic identification of needs and integrated case management, blending that ability to do the medical/surgical part of it as well as the behavioral health part.

And there was a question earlier about what kind of screening is done for behavioral health. And there is a tool that United uses, again telephonically, where they are screening when they are doing their case management assessment. And that, as the representative from Health Net mentioned, is

to help recognize and identify somebody who might have fallen through the cracks, as well as understanding that you may have a medical/surgical issue, but there can be behavioral issues that are complicating that or that result because of that injury or illness.

And next slide.

Warrior Advocate Program, Ms. Harrington also serves as the internal United consultant for other cases that they have at United that may not be in this Warrior Advocate Program. So, those that are in the cancer clinical trials or transplant, she works as a subject matter expert internally at United to help them with all of the issues surrounding active-duty Service members. And she has an expertise in that as well as Terry Pierce.

And it allows for collaboration and coordination of care over time and across treatment settings to improve the outcomes of

the management of the active-duty Service members with complex medical and social problems.

So, that's the unique program that United has developed that they call the Warrior Advocate Program.

There is a question in the agenda about addressing the needs of the caregiver. And I think we all realize that the caregivers become pretty overwhelmed with the multitude of new and somewhat shocking responsibilities that they face. And the Warrior Advocate Program, as well as the other case management programs United offers, recognizes that providing resources specific to their needs can be invaluable.

They recognize that others may have also provided resources to those caregivers and spouses. But, as we know, in these circumstances much information doesn't get absorbed. So, the repetitiveness of it and additional reminder about resources that

are out there for those spouses, I think, and the caregivers is important.

Because they offer this integrated case management and they are working collaboratively with all of these other providers who are involved in the Service member's care, they recognize that transitioning these cases is very important, and that is where we have seen some people run into trouble.

So, we have transitioning from active duty to retired status, active duty to no longer active duty. We have people transitioning from Region to Region. So, there is a formal process for how to do that within the Regions and to the other Regions. So, working collaboratively with Health Net, "We have a Wounded Warrior coming to your Region, and they'll be retiring in the North."

We have an example of one. I was emailing Yvonne today about somebody who is leaving today from the West Region and heading

to the South. TRO South is already aware of it. This Service member, in particular, declined case management services through Humana's program. So, that Service member's care has all been coordinated with the VA that he has been assigned to.

So, the next slide is going to talk a little bit about metrics.

DIRECTOR DAILEY: Hold on. Can I ask a question, please, ma'am? Hang on.

so, when you are transitioning them, and he did not want a transition to the TRICARE management but to the VA, who in the VA are you coordinating with?

MS. REILLY: I will let Yvonne Harrington answer that question or Terry Pierce --

DIRECTOR DAILEY: Okay.

MS. REILLY: -- since Yvonne is actually the one who has handled the case.

DIRECTOR DAILEY: Hi, Yvonne.

MS. HARRINGTON: Hi. This is

Yvonne Harrington.

When we have a transitioning Service member going into the VA, if they are a combat veteran, the first point of contact that we'll make, if the MTF already hasn't done so, would be with the OIF/OEF Program Manager at that MTF -- I'm sorry -- at the VA.

DIRECTOR DAILEY: Okay.

MS. HARRINGTON: And if they haven't, we usually will make contact with the VA to see if there is another point of contact that is not within their combat program, and make sure they have a single point of contact at the VA when they are transitioning.

DIRECTOR DAILEY: Okay. Thank you.

MS. REILLY: So, on to the metrics. The Recovering Warriors served through the Warrior Advocate Program since April 1st of 2013 is a total of 201. So, the numbers are different from what I think the other Regions are reporting. And I would say

that United is still in the process of developing their program. But I think that the way that programs are set up -- and this question came up earlier -- is each of the contractors has developed their own unique program on how they manage the active-duty Service members and, in particular, the Recovering Warriors. So, it is different because there is no contract requirement for it to be the same.

And United has developed their own unique program. And so, currently, they are able to pull data that shows that they have touched at least 201 lives in this unique program.

And then, we have broken it out for you by military grade, which was one of the questions, and then, population by Service. Surprisingly, it was a greater number of Air Force than Marine Corps.

Now we don't do, United does not measure the severity measure that is

equivalent to the DODI Instruction 1300.24, where they get the rating of between 1 and 3. They do a case management screening that determines if a Service member or any case, as a matter of fact, requires case management. And it is a very detailed screening process.

So, if the members would like that, we can provide that after this is over, if they want to see United's criteria for case management and their different case management programs.

The conditions overall we have been unable to provide data related specifically to the Warrior Advocate Program, but the total overall that is active-duty Service members, when they did a data pull, they were able to see that trauma-related events like orthopedic injuries, fractures, dislocations are No. 1 that come up when that data is pulled. And I think that is not surprising. But we don't have anything specific to the Warrior Advocate Program to

provide at this time.

The next slide, please.

And the next slide gives you a percentage or a breakout, that there are 20 current Warrior Advocate cases right now that Yvonne is managing. And the remainder of these Service members are in the other case management programs, specialized case management programs, that United offers. So, there's a total of 61, the remainder being in those other programs. And you can see the breakout there.

And the next chart below that, TRICARE has an enrollment plan code. So, anybody who is enrolled in TRICARE will have an enrollment code attached to them, and they attach the number 415 to anybody who is enrolled to the WTU, to a WTU, and 416 is CBWTU.

And out of the Western Region, there's a total of 1734 with a WTU enrollment code, 361 with CBWTU enrollment code. So,

that's just numbers of who shows up in the enrolled population for the West Region.

The active-duty Service members enrolled with one of those plan codes that sometime has been involved in case management was 44 out of the WTU and 26 out of CBWTU. So, out of that total of 201, we know that a total of, let's see, 70 were assigned to either a WTU or a CBWTU.

Next slide, please.

One of the questions related to the referral process. And the referrals can come to United directly from the Military Treatment Facility, the MTF. They can come from other Regions. As I mentioned earlier, they can come from other case management programs or other departments who have identified a need in a Recovering Warrior.

Internal Utilization Management Staff Coordinators at United also frequently will refer, because they are the ones that are doing the reviews when an active-duty Service

member is hospitalized. So, whether or not it's a planned admission, United does do utilization management reviews on those cases, and they will have an awareness, an alert that there's an active-duty Service member who has been hospitalized. And they may refer that, if it looks like it is something beyond an appendectomy that might need more concentrated level of care.

And the other program that they use -- and we'll go to the next slide -- is a system that is a healthcare analytics tool called ImpactPRO that United uses that helps them identify potential cases. And they can do this through a variety of screening elements that can be customized.

So, they can go out and look at any given time and look for active-duty Service members, high costs, diagnosis PTSD, TBI, trauma, that type of thing. So, they have a variety of different ways that they are able to get referrals, and they have used the

ImpactPRO system in the past.

There was another question about the Reserve component, and that's the next slide. The target population of the Warrior Advocate Program is the active-duty Service members. However, the Warrior Advocate Program case management enrollment is open to TRICARE Reserve Select population with United supervisor approval.

And if a Service member, during the course of the ongoing case management, is, then, separated from active-duty service and is not eligible for ongoing TRICARE coverage -- and an example would be the case I mentioned earlier of a Service member who is transitioning to the South. That Service member has been rated, and his disability does not qualify him for lifetime TRICARE benefits. He will have TAMP. So, he would be an example of that. It is that the case manager will assist the transitioning Recovering Warrior in connecting with the VA, something that Yvonne

has done in that particular case, and other community-based resources.

So, that was one of the unfortunate things about the Service member declining case management services from Humana, but we haven't given up on that Service member. Yvonne asked his permission, if she could follow up with him next month to make sure that everything is going smoothly, and his needs may have changed over the course of his travels to his new place of living back home in the South. And so, he may reconsider. However, he has been provided with all the contact information as well, and he can always self-refer, get some information.

And so, I think the final point on that is that the case manager does ensure that transitional needs are met prior to closing the case. So, they do whatever they can within their power to provide all the resources to the Service member before they close that case.

And the cases can range from a month, a very short period of time, to longer. Cases with potential for long-term case management, those will definitely need transition to either the TDRL list or to the VA.

An example, another question came up earlier about needing an example of VA referring to United. And while this is fresh in my mind, we had a case up in the Minnesota VA, Minneapolis, where it was an active-duty Service member with severe traumatic brain injury. The VA case manager there was working very closely with the United case manager because they needed to transition that active-duty Service member to a lower level of care, a different level of rehab care, because he had maximized his benefits at the VA's Rehab Program.

So, that is an example of when the VA and the contractor can work very collaboratively. That case was extremely

complex, and Yvonne is still following that case. Whereas, the VA case manager stepped out of it at that point because where the case ended up at a different facility, it was closer to another VA. And so, the VA case manager there has picked it up and is working with Yvonne on that.

The case will be closed when the Service member has met all their short-term and long-term goals and objectives, and until we can ensure that the gaps in care closed or the care has stabilized. And, you know, the gaps in care I think is the major issue because I think with the Task Force, one of the goals that you're trying to achieve is finding out what resources are available, what is redundant, and how do we all coordinate this together to make sure that we're not having people slip through the holes in the system.

And all of the cases, Yvonne reviews all of the cases. And she mentioned

this earlier when she was speaking about the VA case. She will close out with the WTU or the CBWTU or MMSO, if they are involved in a case, before the case is closed.

Next slide, please.

It goes into a little bit more detail about behavioral health/psychological health needs. And I mentioned earlier that they are screened and that they have the ability at United to collaborate and co-manage on cases internally. And I think that is a very important resource that is available to us through United, is that they have subject matter experts there who can work, if the primary issue is med/surg, work with that case manager, if those behavioral health needs are something that case manager is unfamiliar with.

And then, they also provide as much family and social support as they possibly can, since we clearly understand that these injuries and illnesses impact the entire

family. And they also have specialized behavioral health medical directors at United Healthcare that they work with when there is uncertainty in the cases or they need the medical director to weigh-in on an issue.

The next case or next slide -- I'm sorry -- is comparisons. There is a question about how does the program or process differ. I think it is a tough question to answer because each of those programs, the non-medical case managers, medical case managers, RCCs, FRCs, Army WTUs, et cetera, are all unique.

So, I think that one thing to keep in mind is that there's a lot of coordination and collaboration amongst whichever one of those different entities is involved in the case or if there's multiple. And care conferences can occur where it is done telephonically where all of those different people are all on the phone coordinating everything that is going on with the Service

members.

And I think what is unique, that's different for what happens in the Military Treatment Facilities, is that active-duty Service members are required to get authorization for any care that is provided to them out in the civilian community, in the network. So, the contractor has visibility of that probably much more easily than the MTF does. There, it has to be a referral to that care, but, then, the contractor has the visibility of the very finer details of that data. And that gives them the ability to do those types of screenings and see who might be a candidate for case management or any other type of service that they can offer.

Next slide.

And then, also, United has been able to refer to other Recovering Warrior resource programs, and Recovering Care Coordinators, they have referred one case; FRCs, five with two pending; Army Wounded

Warrior Advocates, AW2, they have referred one. And then, for VHA, OIF, OEF, O&D program referrals, they have referred six with two pending. So, you can see there is a lot of collaboration on the United side with those resources.

And the next slide, please.

When United, and much like I think the other contractors, was developing this program, they were very deliberate in designing to collaborate with all of those other entities. And again, the Warrior Advocate Program offers consultation only. It could be one-time co-management with other case managers, the example at the VA, or it can be with a Military Treatment Facility medical case manager or with a primary care provider. And they are also actively participating in the DoD/VA Clinical Case Conferences.

Probably in closing, I think that the West Region is unique. We're more rural.

We have a lot of WTUs and CBWTUs. Our Hawaiian/Alaska markets are very unique, in that Alaska being very isolated and Hawaii with the islands, transportation/provider issues can be more challenging because of those difficulties, especially out on the islands getting to Oahu, where the specialty care is more available; the same thing in Alaska.

And I think that --

CO-CHAIR CROCKETT-JONES: We have a question from one our members, if you can hold on a sec.

MS. REILLY: Sure.

MEMBER REHBEIN: Yes, if we can back up I think one slide --

MS. REILLY: Yes.

MEMBER REHBEIN: -- where United initiated referrals, am I to take that to mean that there were some people that either needed/deserved an RCC or an FRC that didn't have one until they got to you?

MS. REILLY: I'll let Yvonne answer.

MS. HARRINGTON: Correct. There are times when some of the case managers at the MTF may or may not have been involved or may not have recognized that one of these cases meet criteria for one of these programs. And at that point, we would definitely assist or place a referral on their behalf, as is the example with these cases listed here.

MEMBER REHBEIN: Interesting. Thank you.

MS. REILLY: So, the --

CO-CHAIR CROCKETT-JONES: And I actually also have a question. Looking at your numbers, do you have the single case manager for the workload, making that caseload, if my numbers are correct, around 20?

MS. REILLY: Correct. The number right now is 20 active cases that are currently in the Warrior Advocate Program that

Yvonne is case managing.

So, that 201 total is the total number from the beginning of April, when the start of healthcare delivery here in the West Region and when United started up that program.

CO-CHAIR CROCKETT-JONES: And just so I'm clear, this is the contracted program? This is not value-added? This was specified within the contract, that this case management be made available?

MS. REILLY: It's specified in the contract language that the contractor can provide services, case management services, to the MTF -- and I'm going to go back to my notes, so I don't misquote myself -- that "allows the Managed Care Support Contractor to work collaboratively with the Military Treatment Facilities to manage active-duty Service members whose care is projected to occur in whole or in part in the civilian sector."

It doesn't specify a unique program particularly for what is referred to as Recovering Warriors or Wounded Warriors, that kind of thing. So, that program that they have developed, I would say, yes, it is value-added, because it is very specific and unique to that population.

CO-CHAIR CROCKETT-JONES: Okay. Well, thank you. I think that we have asked all our questions.

Anything else you want to add for us?

MS. REILLY: I think there was one other question about customer satisfaction, and I'm at the third-to-the-last slide, which is just that the baseline that United has for their standard for care coordination interactions is to develop a process. It is developing a process to ask Recovering Warriors on feedback, on how the program has been supporting them and their satisfaction with services.

But, currently, there is not a tool that is being used to measured that, but that is in development, as well as United is also working with their compliance officer to see if there is an ability for them to do some kind of annual survey. I think Brandi mentioned that they're prohibited from doing surveys. So, that goes through a whole other channel before surveys are allowed, and that is why they are working with their compliance officer to see what they can and can't do.

And then, the next slide is just all of us, our points of contact, myself, Trish Reilly; Shari Erickson; Terry Pierce, the Director, and Yvonne Harrington, who is the Lead Warrior Advocate Case Manager.

And then, if there are any other questions, we'll go ahead and take those now.

DIRECTOR DAILEY: Yes, I do.

So, you did mention -- can you talk to us a little bit about your interaction? You said in one of your slides

that you are working and participating in all the clinical case management focus groups, or not focus groups but conference calls. And can you talk to us about -- I can't remember where that bullet is -- but you did say you are participating --

MS. REILLY: Yes, that they are actively participating in the DoD/VA Clinical Case Conferences --

DIRECTOR DAILEY: Yes, that's it.

MS. REILLY: -- for transitioning Service members.

DIRECTOR DAILEY: Yes.

MS. REILLY: And I will let United answer that question.

MS. HARRINGTON: This is Yvonne Harrington again.

Especially when we have very complex, catastrophic injuries, and the beneficiary is either moving areas, transitioning to different levels of care, or separating from active service, we will

definitely work with the MTF and the VA during their clinical conferences in case there are any network needs, especially authorization for care, making sure that care is not only set up, but maintained for the duration of their active-duty timeframe. And so, we definitely participate to make sure that the treatment plan directed by the MTF and requested by the VA is executed without barriers on the authorization side.

DIRECTOR DAILEY: Okay. And I did find my bullet here. It's under the page that says, "Coordination with CBWTUs and Recovering Warriors". It's that last bullet.

MS. HARRINGTON: Uh-hum.

DIRECTOR DAILEY: It says, "Actively participates in DoD/VA Clinical Case Conferences for transitioning Service members." Okay, so that's individual cases moving between DoD/VA. Participation in the DoD/VA clinical case management policy development, participation in efforts to

deconflict roles, are you involved with that at all, IC3?

I know our briefer, Brenda, talked al little bit about you would be participating in the future in these interagency --

MS. HARRINGTON: Yes.

DIRECTOR DAILEY: -- policy-level activities, not case, not the smaller -- not to minimize a case --

MS. REILLY: Right.

DIRECTOR DAILEY: -- but at the higher policy levels.

MS. REILLY: This is Trish, and I will respond to that question.

The contractor would not necessarily be involved in that level of discussion unless invited. But, at the TRO level, yes, we recently found out about the IC3 group and are working to be able to participate in that and contribute to that. So, I think that's what you're talking about, is the higher-level policy setting.

DIRECTOR DAILEY: Yes, exactly.

MS. REILLY: As well as, you know, we have a variety of roles here, and we work on a variety of different work groups, all involved, that touch on many of the different TRICARE benefits. And some are specific to dependent care, like the ADA programs that are in a constant state of evolution within TRICARE.

But I think the IC3 is the one that comes to my mind that is specific to the veterans and the coordination of efforts. And that was news to us this week. I found out about it this week. So, we are excited to be a part of that.

CO-CHAIR CROCKETT-JONES: Okay. Well, thank you very much. I think the members have gotten all their questions out, and we appreciate your bringing this to us today.

MS. REILLY: Thank you.

CO-CHAIR CROCKETT-JONES: We are

going into a break and be back at 3:15 for our nonprofits panel.

(Whereupon, the foregoing matter went off the record at 2:59 p.m. and went back on the record at 3:14 p.m.)

CO-CHAIR CROCKETT-JONES: Okay, welcome back.

Joining us this afternoon are members of our nonprofit panel. We have Mr. John Hanson, the Senior Vice President for the USO's Warrior and Family Care Program. And we have Mr. Ken Falke, Founder and Chairman for the Boulder Crest Retreat for Wounded Warriors. And we also have Mr. Jim Lorraine, President and Chief Executive Officer for the Augusta Warrior Project.

Panelists will provide us with an overview of their respective organizations, their work with the Recovering Warriors, their input on Recovering Warrior transitions to civilian life. We have briefings under tab N for their information.

And are we going to start with you, Mr. Hanson?

MR. HANSON: Yes.

CO-CHAIR CROCKETT-JONES: Well, then, let me turn it over to you.

MR. HANSON: Thank you very much. Good afternoon, everyone.

These are the questions. You have seen those. You don't need me to read to you on the screen. So, we'll get going.

There's a little known law: every USO presentation has to start with a picture of Bob Hope. I don't want to break the law. So, there's Bob Hope.

(Laughter.)

About 100 percent of what a lot of people know of the USO is our entertainment program. Since 1941, it has consistently been about 12 percent of what we do. But, because of his great work, people know that we entertain troops, and we are proud of doing it. But it is a big 12 percent of what we do.

We have been around since 1941. We're the only group we know of that has access to troops from the moment they enter the Service, in most places through their deployments, and on their way home, and to the time they transition. They're going to be touched by the USO somewhere.

We have an array of programs for wounded, ill, and injured troops. We always have. And we are just facilitators. We don't provide care. We don't have caregivers. We provide help for caregivers in any way we can.

After World War II, our representatives were at VA and military hospitals around the country. Anybody who has been at the former Walter Reed or out at Bethesda, you've seen the USO presence there probably. We are there because troops and families need to know that the public supports them, and that's what we do.

We continue to change to meet the changing needs of troops and families. We

reach out with caregivers' conferences. Currently, we're doing two caregivers' conferences a year. These conferences are facilitated by experts, but they are run by the caregivers. These are places where caregivers learn they're not alone.

Last year there were 150 participants. This year we anticipate there will be more. But it is an opportunity for caregivers to find out they're not the only person with a particular problem they have in their household.

We have employment transition events. We work with a group out of Georgia called Hire Heroes USA. We have been working with them, I think, since 2012. Since we began, 1600 troops have found jobs. Last year we had 1300 participants in programs, about 80 programs last year. This year we look to have 127 programs around the country. We had two last week.

These are high-impact, high-touch

events. They're not jobs fairs. They're places where people learn how to -- they are run by former Marines, one of whom is a former martial arts specialist. So, he gets people's attention and teaches them how to do their resume to where it makes sense to a civilian employer, how to go into an interview. And then, we put these folks together the next day with employers who are ready to hire.

It's a confidence-builder, and we know that in many cases they're not getting the job they are going to have the rest of their lives, but they get their foot in the door and they learn what it is like to be a civilian employee.

Last year we had 23 families strengthening workshops, primarily ones done with our ally, Stronger Families. The workshops are called "Oxygen for Your Relationships". There were 350 people who went through those, most of whom had suffered some of the consequences of frequent and

lengthy deployments and they are just trying to get their relationships back on track. So, we facilitate those kinds of activities.

And I think you know we work with TAPS and have for years. We sponsor a lot of their Good Grief Camps for children and family members who have lost a family member. Last year there were 1,000 participants in the Good Grief Camps that we sponsored around the country.

These testimonies are in your folder. I'm not going to read them for you. But the important thing is we get testimonials, and we get them because we look for, we survey every single person who goes through every single iteration of every single program.

We have about 58 discrete programs, some of which have dozens of iterations all year long. So, it gets complicated, but we encourage every participant to let us know what we're doing

right, what we're doing wrong, and what we could do better.

We look for outcomes, not just outputs. It is important to do that. We didn't know how important that was. It was important to us. But we have since found that a lot of the charity evaluators in a couple of years are going to be changing the way they evaluate charities, and much of what they look for is the impact of what nonprofits do.

We have way too much information to share with these evaluators. So, we have to figure out how to winnow it down. But, for the past couple of years, we have been able to get a lot of input from participants in our programs, to learn what the programs meant to them.

You all know this. About 44 percent of the troops who served in Iraq and Afghanistan have had some sort of readjustment issue, sometimes from complex medical issues, sometimes for other reasons that aren't all

that surprising.

Our focus, though, is on active-duty wounded, ill, and injured troops. We are not a veterans' group; we don't want to be. We don't pretend to be. We couldn't be if we wanted to be.

What we try to do is help these troops as they are transitioning plan for whatever comes next in their lives. We do that at all of our centers, and I will talk a little bit more about two of the main efforts we have in this area.

But every year around Veterans Day our CEO produces an op-ed piece around Veterans Day. Just because we are not a veterans' organization doesn't mean we have to be quiet. And the theme of those op-ed pieces is to educate the public, to remind them that these troops are coming home, that there has to be a national community of care there. We want them welcomed into schools, welcomed into their houses of worship. Find them jobs.

Make them a part of the fabric of the community.

Our job, we think one of our jobs is to hand off troops as they go home and to remind the public that we all have a role in making their transition successful.

The central features of our Warrior and Family Care Program are our Warrior and Family Centers. The first one -- and it is the one on the left -- opened at Ft. Belvoir just about exactly a year ago. Our birthday is next Tuesday, and we opened it on our birthday last year.

It is the biggest USO center in the world, 20,500 square feet, two levels. There are dozens of rooms in there, large rooms, small rooms, a music room, art room. There's an outdoor patio. There's even a golf simulator.

It's on what used to be part of a former golf course at Ft. Belvoir. So, we are trying to simulate the golf course in the golf

simulator.

But it is a USO Center that is aimed at needs for wounded, ill, and injured troops and the whole Ft. Belvoir community. Since it opened last February, through the end of December, 115,000 visits. We imagine by the end of this month, by the end of the first year, year-over-year, probably 150,000 visits to that Center.

On April 1st, no kidding, we'll be opening the next Warrior and Family Center at Bethesda. It is the drawing on the right. It is a one-level affair. It will be the second-largest USO Center in the world, about 17,000 square feet.

It will lean heavily toward the troops who are recovering out at the National Military Medical Center in Bethesda, their families, and everyone who passes through Bethesda.

Now all of our locations offer something for troops with issues or troops who

are transitioning. A lot of it is ad hoc. We say that our folks at USOs around the world solve problems every day they didn't see the day before, and they know that they can find, they can access people to do that.

We touch troops and family members 30,000 times every single day -- that's about9 million times a year -- around the world. So, if we weren't taking advantage of our scope and our scale and our presence around the world, we wouldn't be doing our job.

So, we try to do more than just give them coffee and donuts. In Afghanistan we offer them free phone calls home, which is great, but we try to do more than that. We are a representative of our donors' intent to serve, to lift the spirits of troops and family members, and we do everything we can. We try to fill gaps.

We have a great deal of trust with the Department of Defense and the VA. We build on that trust every day, and we try to

augment their programs any way we can.

There is a question about what might be interfering. I don't think anybody in this room is interfering with anything. If the question is, can VA and DoD a better job, sure, they're the two largest bureaucracies on the face of the earth probably, and they have a lot of moving parts.

Sharing medical records is a good way to begin. Sharing information about disability benefits wouldn't be a bad place to look at, either. And I know that both Departments are trying to do that.

Secretary Hagel used to be at VA, used to be at the USO. He understands this problem, and I think he and Secretary Shinseki are working to do a better at transitioning.

We can all do a better job of reminding citizens that troops are coming home. We think -- and we don't have any evidence of this -- but we think there is almost a perfect sine wave for us of support

from war and peace. When war breaks out, people come to us and they give us money because they know we'll try to take care of the troops. When wars are over, people forget that there are people still in the military or that there were people in the military.

So, our job is to try, one of our jobs is to make sure that people understand that troops are coming home. They are going to be joining their communities. They are going to be looking for work. And we want to be able to help everybody we can.

I used to be VA spokesperson. I'm no longer that person, thank goodness. But when I was at VA, one of the challenges we had was that veterans, many, many veterans didn't know what benefits they had coming to them. And we could all do a better job.

Now what can DoD do better? Our relationship is rock solid with the Department. We work together. I don't know today what efforts. Only I come to briefings

like this and I hear of efforts that the Department and the Services go through to make people who are out processing aware of the services that they're due.

I do know that VA is trying to produce or has produced a messaging platform to let veterans know what programs are available for them to try to drive use up for those programs. Both Departments owe it to the people on active duty and those who are recently off of active duty to know that.

I want to go back to our Centers. We have made our Centers available to the VA because they're already on DoD facilities. We have told the VA and we have told the veterans' service organizations that, if they want a place for intake, for lack of a better word, to go out and teach people, make them aware of benefits coming up, they can use our Centers. We don't charge anything for it. They just have to schedule it.

We think they can come up with a

battle rhythm that makes sense to regularly tell troops and family members. More important than that, than telling troops, I think, is making family members aware of what benefits are available to reinforce the message. So, that is one way we are trying to augment.

This is, how will we change post-war? The USO has been dealing with this since August of 1945. You might not know that in 1947 Harry Truman issued an Honorable Discharge to the USO.

There were USO Centers during World War II at just about every railroad station. Starting in 1946, those Centers started closing down. There was no need for a lot of them. They remained in large cities. They remained near large military bases. But the need for a USO was dwindling.

So, starting in 1947, the USO started closing up its books. And then, spring of 1950 came along and we haven't been

out of business since.

The tradition of our being or changing to meet changing needs, we're already in Australia. We have already set up a small USO Center at Darwin, and we are enlarging that. We are across the Pacific. We have activities in Jordan and around the Middle East for troops who might be going in and out of there. We will be in Kuwait for a while. We will be in Afghanistan for a while. But when we don't need to be there, we'll be out of there.

But we have done this movement recently in Europe. When the military posture in Europe changed, we moved where the military was going. The same thing happened in Korea a couple of years ago.

We are used to responding to the military. We are not interested in operating a Center at an empty base. So, wherever the military goes, we will be there. At our cost, we will be there to support troops wherever

they are.

The challenge will continue to be to keep the public engaged in this because we are not a government agency. We rely on the kindness of strangers, like all nonprofits do, and making the case for what we do will be primary in what we do.

I think during peacetime -- I don't mean this to sound pejorative in any way -- but I think the military tends to be treated like cops and firemen during peacetime. You're glad they're there. You're happy to know they're there. If you don't need them, you don't really think about them until you need them, and then, you hope you have been supporting them all along.

Our challenge will be to dampen-down what we anticipate will be a decrease in the public's attention on the need to support troops and families, and to make them aware that somewhere somebody is walking the wire, serving their interests around the world.

They might not be in combat, but it is a dangerous job and there are a few people out there willing to do it.

So, our job is to remain with them and to keep the public engaged. Right now, we have a couple million dedicated individual donors, some great corporate partners, and we are going to be letting them know over and over again that the USO is still there.

We hope we have set the standards since 1941 in showing America how to support the troops. And it is not always through us. We know what we can't do, and that is why we look for partners like TAPS and Hire Heroes USA and Stronger Families and Ride to Recovery, and other nonprofits, we support to provide direct services because we don't have any interest in doing what we don't do well. We have an interest in making it easier for troops to have access to programs that serve their needs.

I don't know if we're taking

questions individually or as a group. That is it for me.

CO-CHAIR CROCKETT-JONES: I would just like to ask you, how do you identify -- I know when I have had encounters with USO, they generally wanted to see my ID card and that kind of thing. What about family members? I know the Services try to get family members who are going to be involved bedside an ID card. But if you have any insight on how you deal with that kind of issue? And just generally, if you would say a bit more about how the USO feels about caregivers and the current level of caregiver support that is inherent in the DoD system?

MR. HANSON: There are actually a couple of different dimensions to the family member. The family members who have identification, they are welcome in USO Centers. The biggest illustration is our airport centers. People who are traveling can go to the airport centers and wait. Those

centers, if you have been to them, are small.

What we have encouraged -- and we don't operate every USO Center in the country. Some are independent and they have their own -- they get our brand; we give them standards. We give them a little funding occasionally. But some of them raise their own money and have their own Boards. But they carry our brand. So, we try to use persuasion wherever we can.

The best example is the USO Center in Atlanta at Hartsfield. It is a tiny USO Center. It is really overused. And occasionally, veterans will want to go in there because everything is free, and they're welcome, unless it's full of troops. And then, the people there say, "Well, you can see we've got a deployment going on and we've got people coming out of basic or going to basic. So, come back a little later, if you don't mind."

We are trying to change that now

and encourage anybody who wants to go to the USO Center to be able to stick their head in at least and go in and at least be able to see what we offer there, family members, people who aren't associated with the military, just to see what goes on there, with the understanding that if the Center is full of troops, they may not be able to be treated with as much attention as we might like.

Our model is the Families of the Fallen Center at Dover. When the dignified returns were opened to the public and to family members, there really wasn't a place for family members to go. The Air Force had to catch up.

As it turns out, my boss, my current boss, was up there one day and saw what happened. There was a mother and a sister of someone who was coming home for the last time, and there was no place for them to prepare themselves for standing on the tarmac to watch the remains come off.

So, we offered an architect. We offered money, but we offered an architect. And the Air Force answered by coming up with the funding to build the Families of the Fallen Center. We augment it with volunteers from the two USO Centers we have at Dover, as a place that is not a USO Center, but it feels like a place of comfort and care.

There are two USO Centers at Dover. One is pointed directly at the people at the port mortuary, the volunteers who work there and the troops who work there, because it is a really stressful job and they need a place to catch their breath. And then, there is a USO there for the rest of the base. It doesn't matter who goes where, but each one of those Centers has its own mission.

So, we are trying to expand access as well as we can, understanding that, if a Center is full, a Center is full and the primary purpose is to serve troops and family members.

That will not be a challenge at either Bethesda or Belvoir. These are gigantic institutions. These are huge buildings.

If you haven't seen our Center at Belvoir, you ought to go. It's spectacular. It is an easy post to get onto. Go look at it. And you can see, you might get an idea of the kinds of things we're offering.

What we have found is that the care being provided on the base sometimes lacks facilities where that care can be given effectively or the facility might be full. So, we can be an overflow.

We have had a discussion at Bethesda already about arts therapy at the USO to supplement the art therapy that the NICOE is going to be offering. We already are going to have an arts area there anyway. In both places we have a big room. Big rooms are rare on military installations. So, they can be there for transition briefings, for medal

presentations, for any other kinds of presentations. So, we are there really to supplement.

The reason we offer caregivers' conferences is because we saw a need. We had caregivers coming to us asking questions that we couldn't answer. And we made an enormous mistake with the first one. We did it in El Paso, one of the most inaccessible places in the United States. And we found out right away that these were sessions that couldn't go beyond 2:00 or 2:30 in the afternoon because these caregivers had kids to pick up at school.

And we learned an awful lot. We learned that no number of experts who came in to offer advice were going to be as compelling or as interesting as the caregivers themselves telling their own stories, supplemented by facilitators, not by speakers.

So now, our caregivers' conferences tend to last a couple of days, a

couple of half-days, and they are driven by people who have gone through dealing with someone who has had to deal with any number of issues from potential suicide to "How do I take care of someone who is just depressed all the time?" And occasionally, we bring in the family member, the Service member as well, just as a learning experience.

Now, when you do two a year, you can't really touch a lot of people. So, if we get 300 or 400 a year, we're doing that much. I hope that what the Department is doing is bigger. And if there is something we can do in concert, then we can have a conversation. Maybe we can have four or five a year. But we are doing this out of hide. So, we're trying to do that.

Sorry to take so long, but these are complicated things.

CO-CHAIR CROCKETT-JONES: Thank you.

MR. HANSON: Thank you.

CO-CHAIR CROCKETT-JONES: And I think next we have Mr. Ken Falke.

MR. FALKE: Falke.

CO-CHAIR CROCKETT-JONES: Falke.

MR. FALKE: While the slides are coming up, I'll just give you my quick background. My bio is in your book.

I got into the Wounded Warrior care business, if you will -- in 2004, I retired from the Navy as a Master Chief Petty Officer in the EOD Tech. And the first EOD troops that were injured in Iraq, my best friend, who was killed later that year in Iraq, was a Sergeant Major of the 52nd Ordnance Group, and called me and said, "I've got an EOD troop coming to Walter Reed. I know you're in the D.C. area. Could you meet them at the hospital?"

So, my wife and I said we would be honored to. We got to the hospital. A young man was laying there with no legs, with no mom, no wife, et cetera, et cetera.

I said, "Where's your mom? Where's your wife?" He said, "I'm not married. My mom's in Kentucky. She is trying to get somebody to watch her dog. Can't afford a plane ticket. She's driving. She'll be here in three days."

So, we took my wallet and my cell phone. We called the mother, got her on an airplane and brought her to the hospital.

Quite frankly, because I was in the first Gulf War and in Bosnia, I thought that that would be the first and the last time I did that. I did it 11 more times before it started stressing my wallet out, and my wife and I started what was called the Wounded EOD Warrior Foundation. Today it is the EOD Warrior Foundation.

I sold a company in 2008 that I left in 2010 and went back to school at Georgetown to do a master's degree in public policy. And it just so happened to be the worst year for EOD troops in Afghanistan. We

had 71 amputees between I think April of '10 and May of '11. When I was in school, I was on one end of Wisconsin Avenue. So, in the evenings, I would drive up and spend time with the families.

For those of you that don't know, on average, the inpatient Wounded Warrior, physically Wounded Warrior, at Bethesda will stay in the hospital for about three months and an outpatient for a year. I've got some that have been there for four.

We, being my wife and myself, and now my Board -- our foundation is much larger today than it ever has been on the EOD side -- started bringing these families out to our home. We have an estate, a 200-acre estate in Bluemont, Virginia, a 100-year-old farmhouse, and 37 acres of the property we never really used, other than take the hay off of the property for a local horse rescue farm.

We were lucky that our property subdivided by tax parcels. We went to the

County. Thank God, one of our County Supervisors was a retired Air Force Colonel. We told him what we would like to do with the property. We wanted to peel 37 acres off and build a retreat for Wounded Warriors and their families to be able to come away from the hospital and just basically get R&R away from the hospital facilities.

We also saw that, you know, when you are in a hospital for a year and you're eating hospital food for a year, and that is miserable as well. So, we found that getting families out, getting them something healthier to eat was very powerful.

One of my first honorary Board members is General Hugh Shelton, who served on my for-profit company. I called General Shelton. We initially were going to do this for EOD and Special Forces troops only.

It just so happened to be one night, as I was leaving the hospital, there was a young soldier laying in his room by

himself. I popped in to talk to him -- it was Christmas Eve -- to find out that he had no family, no wife, no special 501(c)(3), the Green Beret Foundation, the EOD Foundation, any of the Special Operations kind of foundations to help him. And he was sitting there by himself and feeling pretty sad and lonely.

And as I was driving home, I called General Shelton and I said, "You know, I think we really ought to open this up to all Wounded Warriors and their families, not just focus on this community." And he agreed.

I spent, as an EOD guy, about 10 years of my career supporting Special Ops, and that's where the connection to that community was.

So, real quick, I'll run you through the mission. We have built a first-class retreat. It literally is a first-class retreat for Wounded Warriors and their families to come and rest and reconnect

together.

It's in Bluemont, Virginia. That's one hour west of the city, straight out Route 7 between Leesburg and Winchester.

We serve any -- we have a very gray area, which I'm proud of -- we serve any military or served veteran, serving, active-duty or veteran, suffering from combat stress. And we do not distinguish between combat -- or we do distinguish between combat stress and PTSD or PTS in the sense that we also know that some people are much more resilient than others, and sometimes it is a family member suffering with stress of combat. And we welcome them, if that is the case. So, we are very open in that gray area.

We focus our programs around couples, families, male and female independently, Wounded Warrior population. We have a caregiver program. We have just hosted a couples program. And also, military sexual trauma survivors. We're hosting a one-week

program this week, and we hosted the first-ever male MST program late last year through a nonprofit called Artemis Rising.

We thought we would serve about 250 to 500 families a year, and I think that number is probably still accurate. What I will say is in total people -- we opened up last September; the Vice Chairman was our guest speaker, flew out to the facility via helicopter. It was a great day. But we opened up September 6th. And September 6th to December 31st, we had over 300 people in the facility. Now that is family members and everybody. So, we think it is going to be about 1,000 people a year.

We provide accommodations. We have non-traditional therapies from equine therapy, EMDR, meditation programs, both mindfulness and transcendental meditation, yoga, all non-traditional. We will look at anything that is focused non-traditional.

And then, we also have recreation

therapy. We are at the foot of the first Blue Ridge Mountain range. On the Blue Ridge Mountain range is the Appalachian Trail. Just over the mountain about a mile and a half from us is the Shenandoah River. So, we do kayaking. We do fishing in the Shenandoah, hikes along the Appalachian Trail, those types of programs.

The next few pictures are literally just pictures. This is our lodge. It is about 11,000 square feet. Everything out there is timber frame construction. This is all private money. There is no federal government money for the project.

I will tell you that most of the healing that is going on out here is going on around those fire pits. I'm glad my landscaper talked us into two of them. It's amazing what people will do sometimes when you're not looking them in the eye in the evening and what they will say, even in that little bit of darkness.

The next picture if the Great Room, which is the upstairs room of the lodge. We reconfigure it for everything from yoga to meetings. We held our first -- JPMorgan Chase gave us some money to host an employment seminar, a very focused seminar. We had 25 people. We had three CEOs come in from different organizations Saturday, this past Saturday, and actually talk to transitioning active-duty military personnel. It was a great program. We're going to host four of those, I think, this year. But we can do anything from host day-like programs to do a yoga class in there.

Downstairs this building includes a kitchen, courtesy of General Electric, provided all the appliances. In addition to raising a lot of private money, we had a lot of in-kind donations. General Electric was one of our big donors.

Again, that is the kitchen/dining area. Music, art therapy on the other side of

the kitchen downstairs. Some of the retreats we host we actually do journaling and creative writing and those types of programs, kind of going in that relaxed living-room-like facility.

The fire pits are huge. I think they are 6-foot across, and you can get probably comfortably 20 people around them.

We have four cabins. One of my Board members, Ike Skelton, honorary Board members, who was our first honorary Board member, passed away late last year.

Ike Skelton had polio and he grew up in camps in the summer. When we went into this project because we have 37 acres, some of the Board members wanted us to build more cabins. My personal opinion is that I think a lot of nonprofits try to do too much for too many. Our motto is healing heroes one family at a time, very high-touch, high-impact.

We said if it was successful and we could perfect it, that maybe we would look

at going out and raising more money and building a handful of these around the country in high-veteran population areas.

That's an upfront picture of the cabin. They're beautiful cabins. You'll see some pictures inside. They're not small cabins. They're set up for a family of six inside.

We had no intentions of putting granite on the kitchen countertops, but the local support in the community embracing of this project has been unbelievable. From the gravel on the roads, the guy that owns the quarries in Virginia, Charles Luck, is a VMI graduate. He came out and said he wanted granite in the kitchens and we got granite countertops in the kitchen.

The flooring came from Lumber Liquidators. The Trex decks, the CEO of Trex put the decks on the facility as well. All the furniture in there is from a company in Kentucky.

I have an Air Force triple amputee EOD guy and another Air Force single-leg amputee. I flew out to the furniture in Kentucky. We wanted not to be only ADA-compliant, but ADA-friendly. So, everything in here you can transfer from wheelchair to bed easily. The shower in the main bathroom was designed by a Marine Corps triple amputee. So, it is very, very handicapped-friendly.

Every one of the beds has endless numbers of quilts. The quilting community gathered around this project like you wouldn't believe, and some beautiful quilts on all the beds. And that has been a blessing as well.

So, we've got a king-sized bed in one room, a queen-sized bed in the other room, and a set of bunk beds for the kids and some of the Wounded Warriors as well in the fourth or third bedroom.

Nice big decks on the back of all the buildings, and that's what they look like. And they're all done by Trex and all lit.

We have an archery range and a labyrinth in the back field. A labyrinth is a form of walking meditation. We have an archery range that has been a big hit. And that was just one photograph that I was real happy with. The guy pulling the string back was shot seven times in the arm with an AK-47, can't move his left arm. The guy on the right lost his right arm. The guy on the back is a quiver. So, it's teamwork on one of the first retreats we hosted.

So, I think we had some questions to answer for you. The first one was long-term services that are needed. The data that we know indicates that approximately half of the veteran population does not seek services from the VA. We know that stigma very well. We're trying to make sure that that's not the case. We're very open to this gray area of combat stress.

The gap in the services continues to be needed. There's no shortage -- I think

somebody said 45,000 nonprofits. I would love to see that list. I've heard anything from 200 to 45. My personal opinion is it may not be enough. Some people think it is too many. And I know some people want to control them all, but at the end of the day it is amazing the work that's going in this country by people. Whether it is a single therapy dog a year or the USO, it's amazing what is going on in this country on private money.

What we offer is rest and reconnection time. Sometimes families want to come out and they just don't want to do anything, and I love that.

You know, my wife and I have been married 31 years. In the military they say, "EOD stands for everyone is divorced." The Special Ops community, it's 95-percent divorce rate. And I know that you can get through it and get through the ups and downs of life if you have quality time as a couple, and that's kind of what we do.

So, we provide this rest and reconnection. We stay clear of any pharmaceutical solutions. We're not in the business of medical or pharmaceutical solutions. We're looking at those alternative therapies and modalities that are focused.

The one thing we haven't built yet, and we're still looking for a donor, is the walled garden. We are going to build a fully-accessible walled garden, not only to bring food into the kitchen for some of the cooking classes and things that we do, but also as a place of therapy.

The next question was, how prepared are the DoD and VA? I have watched this since the beginning with my EOD foundation. I think the progress is remarkable, I guess is probably what I would say, from the facilities, from what used to be at the Malone House to Building 62, the facilities in general, but just the services I think have been much, much better.

I have been saying for about 10 years now that, as these physical injuries wind down, I think the Post Traumatic Stress injuries will wind up. We all know the stigma. I think everybody agrees to the stigma. I think as the war winds down, the downsizing occurs, I think you're going to see a lot more PTSD claims, and we are trying to prepare for that.

We serve not only severely-injured, but, obviously, the combat stress as well. And we see that as a big gap because a lot of people that are in this business -- there are a lot of organizations that stay really focused on one type of injury. Maybe it is a physical injury. You have to have an amputation if you go skiing on this trip in Aspen. We don't look at it that way. We look at this whole community and try to see where the real gaps are.

What we really see is an opportunity to perfect these non-traditional

modalities. And I know we have talked -- and Gen and I sat here yesterday and listened to the discussion on evidence-based therapies. Although I'm a firm believer in it, I'm also a firm believer in paralysis or analysis and paralysis by analysis, whatever you want to call it. But, you know, long-term studies -- there's a lot of people that are in need of help -- I think long-term studies are going to just make for a lot more backlog.

So, we are willing to try anything. It is amazing what a day on an archery, it is amazing what a day kayaking will do. And I know that recreational therapy has a lot of evidence-based research, but at the end of day it is amazing what that will do.

I told somebody once, and I had a psychiatrist, and he looked at me like I had three eyes, that I'm not as sure -- I think one of the big mistakes we have made in DoD and the VA is combining TBI and PTSD in the

same language. There's no doubt that TBI complicates PTSD, but I'm almost of the mindset, after watching the people come through our facility, that PTSD is more of a disease of the heart than the brain. And I can tell you a lot more about that.

The trauma that we see processed, it goes way back. It is not just military trauma. So, when you see real severe PTSD cases, the trauma probably started a long time ago.

And I'll just give you one example. We hosted six men who had been raped on active duty, the MST program. Four of the six had been raped since they were six years old. So, it is just a really interesting dilemma of what type of trauma is in these folks before we even get them in the military. And we've got some thoughts on that as well.

One of the things that we think is there's a way of leveraging existing infrastructure rather than building high-

dollar facilities like this. You know, the VFW and the American Legion have some great infrastructure. I'm a lifetime member of the VFW. We have a million-dollar facility in Berryville, Virginia. Right now, the population is primarily Vietnam vets. There are some Korean War vets and one or two World War II vets left in our post. But I think, as time transitions, I think figuring out a way of leveraging some of this infrastructure could be very interesting for this new generation of war-fighters that suffer. And that is something we are really interested in.

We also, like I said, are very interested in looking at some what I would call revolutionary-based private/public partnerships. And I don't think that has been explored enough yet. Because when you look at the amount of money spent on healthcare and you look at the amount of money spent for us to take a family in, which is 200 bucks a day, I think for a little bit of public money, we

could do a whole lot more work. And that is something that we are exploring.

The next slide, the question was, what interferes with transition? We said there's not much interfering with access to Boulder Crest. To get a reservation at our facility, you literally just go online like you would a hotel. And then, our community outreach person and reservations person at the facility will work with the family to ensure that we understand that they do have, in fact, combat deployments. And if that is a DD-214 that is provided, if it is a letter from a Base Commander or a supervisor, we're okay with that.

We have debate over and over again: is anybody going to rip us off and come there and say that they had combat time? We probably think so, but at the end of the day, if one person slips through or one family a year, we are not going to worry about it.

There's no cost to the individual

warrior or family. If the retreats are fully paid for, the family R&R stays, all they have to do is get there and pay for food. And even sometimes the food is provided.

We had four families over the holidays, Christmas Eve. And a friend of mine's wife is a pastry chef in D.C. She brought a bunch of chef friends out and they cooked a breakfast for free. So, those are the kinds of things that are going on with the community.

The one thing that we think in transitioning or using our facility is an obstacle is the awareness. We haven't done a great job of -- it has mostly been word of mouth. So, we are working harder this year, because we just opened last year, to let people know we're here.

And I think the second-to-last question was, how can DoD improve transition? I have transitioned. I never looked back. I started a company. It went from 50 to 500

employees in a couple of years. I hired 300 transitioning veterans into a company of 500, personally sat through 300 interviews of 300 people that we hired, mostly EOD and Special Forces MOSes in my company. And so, I have a little bit of experience. I'm probably not an expert.

I do think one of the challenges in the VSO world, MSO world, we keep hearing over and over, how do I know what resources are available? So, if I transition back to Bluemont, Virginia or Loudoun County, Virginia or Martinsburg, West Virginia, what are the nonprofits that are in the area that are available? And I don't think anybody has done a good job.

I mean, I have literally heard the number 45,000 VSO/MSOs to 250,000. And I'm still not sure anybody got the list. I've listened to Dave Sutherland say those numbers for probably four or five years now. So, I mean, I would love to see the list myself,

just to really see what we have and, then, figure out how to catalog it.

And along those lines, we thought maybe creating some kind of a catalog, you know, like the Veterans Job Network, where all these VSOs are listed in there. There are a couple of things, the National Resource Directory, some of these databases that are pretty full, but not everybody is in them. I have gone through them.

The challenge, by the way, of getting your VSO or your MSO into the National Resource Directory is not easy. So, maybe making that access easier for organizations could be good.

And then, how do you publicize that, which is always a big challenge? How do you get out to a 22-million-person population and say, "Here's the websites" or "Here's the portal."? Not that I think we need a single portal, but I do think we need better information on what is out there.

The last question you posed to us was, will your activities change? We don't think so. I will tell you that, when we started planning this retreat facility in 2010, I thought that the majority of our guests would be amputees from Walter Reed and Bethesda. That has not been the case. We have had as many active-duty as we have had veterans, and we have had more families suffering with the effects of combat stress than we have had amputees. So, that is probably what we think will continue to happen. So, we don't expect anything to go.

We expect to continue our mission. And obviously, we will get better and smarter as we continue to run the facility.

And finally, we really hope to serve as a model. We probably get, without exaggerating, we probably get two phone calls a week on people who have been given property or have a similar idea. I tell everybody, "Don't do it yet." At least I don't want to

provide advice because I'm not sure we've got it right yet. I think we will be the leader in this space, specifically on the therapeutic side, but I do think there will be a lot more facilities as far as the recreational therapy, families who own anything from timeshares to family estates who will donate them and allow people to come stay for free.

I do know of one wealthy guy in Idaho, up in Sun Valley, Idaho, who just gave away a fairly-substantial piece of real estate for Wounded Warriors only. There's another guy in New Hampshire right now working on something. There's another guy not far from our facility who has been in the newspaper recently that's trying to build something.

So, I do think this will be something more, but at the end of the day it is not just about R&R. And I don't want you to take away that this is a free vacation place for veterans because the therapy that is going on out here is world class.

And when I say "world class," I know what it is because I spent, as an executive, I spent 10 years going to the Mayo Clinic and getting executive physicals. If you have never done that and you can afford it, go do it because you will never have a medical experience like that again in your life.

What we are offering out here is world class. We have got therapists that I don't think would want to be working inside of a bureaucracy. And that is no disrespect to military medicine. But I am telling you, the people that are delivering therapies out here are unbelievably talented.

I would never in my life have believed that somebody suffering with something as dark as sexual trauma would walk away from this facility in three weeks and say it was life-changing, and not only say it was life-changing, but to see it in their faces.

So, thanks again for having us

here, and I'm happy to answer any questions.

MEMBER REHBEIN: Sir, a few months ago, on one of our visits we were in Park City, Utah at the National Ability Center. Some of what you talk about reminds me very much of some of the things that they are doing out there. Is there any conversation that goes on between existing facility to trade knowledge and best practices, what works, what doesn't? Is there anything organized along those lines, experience that can be drawn on?

MR. FALKE: I was going to say yes, until you said "organized".

(Laughter.)"

I do think there is a lot of great discussion going on. And funny enough, where a lot of the great feedback and knowledge-sharing goes is from the Wounded Warriors who attend these things. So, the guy who is skiing out there or cycling with Race Across America, or whatever the event is, when they come to different facilities, they will make

recommendations.

The one thing about our military and veteran population, they're not shy. So, we do get a lot of great feedback. And then, the caregivers, I mean, the caregiver side of what we do and the caregiver retreats specifically, I mean, they are not shy. They will tell you exactly what you need to do to get better and what you can do.

I think the major adaptive sports centers do collaborate a lot. We collaborate with certain modalities that we work. So, like equine therapy, we have had a bunch of people that are in the equine therapy business that we have had discussions with. We don't ride. So, there is a difference between therapeutic riding -- sometimes when you say "equine," people just think they're getting on a horse's back and going for a ride.

We do something called HIGH, which is Horse-Inspired Growth and Healing, which is work that is done with the animal on the

ground. It builds a level of confidence when you are working with a 2,000-pound animal on the ground, not much different than dogs other than the size really, but very, very therapeutic.

I had a Delta IV Sergeant Major -- and I'll just tell this one story because of how important these modalities can be. This guy walked in, and a typical Delta IV Sergeant Major; he wasn't sure who was in the room. He had his back to the wall. He had his rucksack on his shoulder and he never looked up. He looked at the floor. And this guy is suffering from, I think, 13 deployments to Afghanistan and Iraq, and definitely suffering with Post Traumatic Stress, and never looked up off the floor.

And we took him -- and I've got the picture on my phone, if anybody wants to see it -- I took him to the equine. And within 10 minutes, his demeanor changed like that. And if somebody would have told me

petting a horse was going to change a Delta IV Sergeant Major's demeanor 10 years ago, I would have called you a liar, but it was amazing, an amazing response from what's going on with these non-traditional therapies.

I don't know if that answered your question, sir. But if I could say one thing about these things, it is be careful in looking for that evidence because it is a smile, a handshake, and a hug that makes a big darn difference.

CO-CHAIR CROCKETT-JONES: Thank you very much.

Let's move on to Mr. Jim Lorraine.

MR. LORRAINE: Hi there. Just as my colleague did earlier, my bio is in the book. But my background is United States Special Operations Command. I stood up the CARE Coalition. Kevin McDonnell took my place, followed me there. Before I left, I worked for the Chairman as a Special Assistant.

Left both of those jobs because I was a military caregiver. My wife is active-duty Air Force, got real sick, and I had to leave both jobs to take care of her. So, my perspective is from active-duty military, ran a program like this, became a caregiver, left my job, moved back home to her family, so that I could press forward going forward. So, that is my perspective.

I want to thank my colleagues here. Great programs. I'm going to get you afterwards and we're going to fill your place with Augusta.

But our program is a little bit different. We are a community-based program. Our mission is to improve the quality of life of warriors and their families that live in the central Savannah River area. To get an idea, as it says at the bottom, it's 13 counties around Augusta, Georgia. Nine counties are in Georgia; four counties are in South Carolina.

So, when I deal with a bureaucracy, I deal with seven municipalities, 13 counties, and two states. So, what is the issue in South Carolina isn't the same issue in Georgia. So, we balance that.

And again, when I say "warriors," our definition of warriors comes straight out of the dictionary. A warrior is somebody who is either engaged or experienced in warfare. That's either a military or a veteran and their caregivers. So, that's where our focus comes from that effort.

All eras, World War II to a kid who just gets out of the military today. So, it's all eras.

These are the numbers, and they are in the ball park. So, if anybody has a dispute over the exact number, they are in the ball park.

What we are focused on in Augusta is the 66,000 veterans who live in the CSRA and the 8700 post-9/11 vets that live in the

CSRA. Our mission is honestly to find them all and to identify who they are.

This is the system to a kid getting out of the military today. It is just a puzzle. They come out of a great TAP glass and GPS, and all the other programs out of Camp Pendleton, and it was taught at Camp Pendleton.

And then, they fly home and they end up in Augusta, Georgia. And everything that they learned at Camp Pendleton, the concepts are the same, but the contexts are completely different.

If you live in South Carolina, you're getting your healthcare from the VA in Georgia, but you're filing your claim in South Carolina. The Vet Center is in Georgia. You can be in South Carolina. You have to register. It just doesn't make any sense.

So, what our effort is, our effort is to take that puzzle and put it together. And the way we do it is four steps. It is

connect, educate, advocate, and collaborate.

The connect, our goal is to find and build a relationship with every veteran in our community. In the 18 months that we have really made a forced effort at that, we are at 4,000. Most of the veterans -- I spoke at a MOAA event, sat at a table. Vietnam era veterans, medically service-connected disabilities, sitting around the table, four of them; none of them were enrolled in the VA, none of them.

So, what we did was we went back to the next meeting with the VA and enrolled every single eligible veteran in the VA. We said, "Hey, we're going to bring it to you rather than us bringing it to them."

And then, the next ask is, "I want you to find five more and bring them to us, and we're going to help you connect."

Educate. It's really about how do you -- you come into a community or you go through TAP or you go through another program,

and what's available to you on the outside? Unless you know the system, you don't have a clue. And it may be case-specific.

So, what we do is we educate the warrior on what's available to him and their caregiver about what's available to them not only in their community, but within the state and nationally. It is our job to know what is available, where it is, and how to access it.

And then, advocate. If they hit a roadblock, we advocate on their behalf to bypass that roadblock and to move it along, press it along. Our focus is results. We don't want to sit and have a discussion. We want the results and get to the endstate to have a positive outcome overall.

And collaboration is important. We collaborate with everybody. We don't have any MOUs. We work closely with other partners. Our job is we'll find your customers and we'll bring them to you, but you have to provide the service. If you don't

provide the service, we'll go to somebody else, and then, they'll provide the service.

And what we found is, when I came to Augusta about two-and-a-half years ago, there were about 20 nonprofits -- I think there are 45,000 -- there were about 20 nonprofits in our area that were in this space. And they were local; some were regional. Ten of those nonprofits are now gone because they just couldn't provide any service. It was either they didn't provide service or they were more focused on fundraising than providing the service. So, we just bypassed them. Because it was about how are you going to contribute to the endstate and the goal.

How we do it is that we build a relationship with all these community programs. It is sort of an eye chart there, and it is in your slides. But we look at school, healthcare, VA, the VA services, housing, all the service providers, and then,

jobs.

We build a relationship with employers, with the Georgia and South Carolina Department of Labor, but, more importantly, with the employers. Because what we want to do is we go into the employers and we say, "I want to help your veterans that are here. Most of them are eligible for the GI bill. I want to help them go to school, so that they can become a better employee."

The other thing is, when the government shutdown happened -- we have a lot of federal jobs -- the Department of Energy had to furlough a number of people, and the contractors fell into the same thing. We had a relationship built with the companies. So, instead of sending them over to the South Carolina Department of Labor, all the veterans came to us, and we rolled them in to make sure that they had their healthcare, made sure that their families were taken care of, got them into education services that they could use

while they were over the shutdown, which for some of them lasted about four months. Used federal and non-federal programs, and then, got them back into the employment.

The benefit was the employers said, "If you're going to do that for my employees, I want more of them." And so, then, they came back to us with a requisition when the money kicked back in at October. They came back to us and said, "We're going to up our staffing by 20. I want 20 of them, 20 more vets."

This is our biggest problem, is finding them. And we're doing it through branding, through commercials. Our commercials that run on television in our local area say, "If you wore the uniform or your nation and served your country, and swore to defend against the Constitution, against all enemies, foreign and domestic, we want to know who you are. You earned services that you're entitled to. Please let us know who

you are and we'll help you." Even if they don't need help right away, we just want them to know that in the back of their head, that they can call us and that we'll help them.

This is how we do it. So, we just don't focus on -- I'm sorry, I'm completely blowing this in terms of where the button is -- so, we don't focus on one piece. Our focus is the center, which is quality of life.

So, if someone comes to us and they say, "Hey, I'm having a housing problem," I guarantee you their issue isn't housing. It's probably education. It's probably employment. It's probably their access to healthcare, Post Traumatic Stress, TBI. Whatever the contributor is, their issue is not housing. The symptom is housing, but not the core issue.

So, everyone we meet, we say, "So, how are you doing?"

You see the spirituality piece there. In Augusta and in the area that we

live in, churches are a big thing and they have an enormous amount of resources, resources that on a national level, the TRICARE groups, they would never know that they existed there, but they provide a vast amount of counseling.

I can tell you that our social workers don't run into a lack of counseling services in our community. People can get right in, whether it is through the spiritual, through the VA healthcare, through the community programs, through the Georgia Regents University, which is our medical research center. It's you've got to know what's in the community and what they're offering, and then, plug the people in. Plug the people in.

So, we focus holistically, and you see our name wrapped around the outside with our community partners. But we don't provide any direct services at all. We are truly navigators of the system. Understand what the

issue is with the veteran and navigate through it.

So, quickly, I'll run through this. Process and action. A warrior comes to us with a question or a life issue. We understand it. We know the warrior. We know the question and the issue. And what we do is we develop a plan. Then, we turn that plan down to our partners, the community partners. And some are national partners.

So, if someone would benefit from a retreat, I'm going to call you and say, "Hey" -- there's a couple of things that have to happen first, but one of the steps in the process of success would be to go to Boulder Retreat.

I don't mean to keep poking you.

So, we bring this down to the community. We sort of synchronize the approach. We say, "Okay, you're first, you're second, you're third, you're fourth. Here's what I need you to provide." They go, "Roger

that," and then, they provide the service in that order to the warrior.

And then, we do another thing. We follow up with both. We follow up with the warrior to say, "Hey, is everything on track? Okay, did you clear that first step, that first gate? Now let's move to the next one."

And then, we go back. If they say, "Yes, I'm good to go," we go back to our partner and say, "Hey, thanks a lot. You did a great job." If they say, "Do you know what? Nobody called me back," we circle back to that nonprofit and say, "Did we communicate wrong? Is there something going on here? You need to provide this. Let's step in and do it."

I thought this was cute.

So, anyway, in the endstate, you bring it all together, bring all the puzzle together. The warrior is happy.

Our work locations, we go to where the veteran is, the warrior is. So, we work out of the Salvation Army, which is the Kroc

Center. It is like a one-stop in Augusta. And that is where we launch from. But we have folks who work at Aiken Technical College, the University of South Carolina, Aiken; out of the Goodwills; Ft. Gordon, we have two seats at Ft. Gordon working for the Garrison Commander there. The local VA uses us also. Again, it's 13 counties, a pretty big area to cover. We have the tyranny of distance for us.

These are our partners, national and local. We are not restricted. We will work with anybody.

So, we worked with the USO and the Gary Sinise Foundation to bring Gary Sinise to Ft. Gordon to perform for the troops that ended up getting stuck there. There was a heat spell and they closed down the post. Everybody was ticked. They couldn't go outside. They couldn't do a lot of things. We got Gary to come out to play. The USO helped us to do it. We worked with the

foundation. The troops came out at night. He performed, had a great time, almost got blown off the stage from a tornado, but that is beside the point.

Anyway, we work with everyone. In terms of VSOs, we're not a VSO. We work with VSOs to do claims/benefits.

Here's our results since February of 2012. We have virtually eliminated veteran homelessness from Augusta, Georgia. We had 195 homeless veterans. The official count today is six.

In that time, in that period, we worked and got 220 -- when I say they're permanently housed, they're paying their own rent. I just had one of our folks who we engaged with 18 months ago who purchased her own house through a VA loan because she went from homelessness. We got her into school. She got a job. We got her to a consumer credit counseling service, a local one, cleaned up her credit, got her rating above

where the VA could give her a home loan. She bought a house. She was the first person in her family, a female veteran, Desert Shield/Storm. Desert Shield/Storm, not post-9/11.

And I will tell you, at a community level, when a post-9/11 veteran comes into us, they are easy because they have so many services and so many programs that are targeted toward them. But, once you cross that bridge, if you got out in 2000, God help you; there's not as many resources and services that are available. I see Ron shaking his head. You know exactly.

Five hundred and thirty-six enrolled in colleges and training. Remember back to our mission. Our mission was focused on improving the quality of life within the community.

So, the message to the warrior is, "Hey, we want to take care of you because it's the right thing to do." The message to the

community is, "Veterans are economically-smart. So, if have 20,000 post-9/11 veterans come to our community and use their GI bill, that's $500 million a year in federal GI bill funds that come into my community. Why wouldn't I take care of them? Why wouldn't I take care of them?"

And that doesn't count disability benefits and voc rehab and all the other pieces. That's just the GI bill.

So, we tell the community leaders and our businesses, "Doing this is smart for the community." We tell everyone else, "It's also the right thing to do. It's also the right thing to do."

Unemployment, 195 unemployed warriors employed. Again, it is because it is a personal relationship with a business at the local area. This is not the 100,000 Jobs Initiatives, because I can tell you in Augusta, Georgia, JPMorgan and these major companies are not there. It is a mom-and-pop,

small business. I always say, "Who's the biggest employer in the United States?" Small business, and they're in Augusta and they're in my region. And they are where the veterans want to live. You just have to find the opportunity for them.

We increased the VA enrollment. One of our policies is, of the 3800, everyone we meet, 100-percent enrollment in money benefits, 100-percent enrollment if you're eligible in VA healthcare, 100-percent, if you're eligible, enrollment in the Wounded Warrior Project. They are one of the main programs that we use.

We are going to leverage all the resources we can to help you.

I know I'm running out of time. I'm running over. So, just bear with me here one second.

And again, 3800, our number is now, since I sent this to you, we're over 4,000 now. We had a big push.

So, this is our national outreach. The Wounded Warrior Project came to us and said, "Hey, we really like how you're doing business. Can you replicate this in five communities this year, five communities next year, five communities going forward?"

And so, our goals are pretty tough in this program. Because of the Wounded Warrior Project, we bring the funds to the community, so that they can focus on doing the work and not necessarily doing the fundraising. We want them to get results that resonate within the community, so the community, then, can resource and fund them.

But if you look at the measures here, we want to find, in 36 months we want them to have a personal relationship with 80,000 or 80 percent -- 80,000? -- 80 percent of the post-9/11 vets.

In Tacoma, Washington, where we just engaged with, that is 20,000 troops that this organization will get to know.

Ninety percent graduation rate. It is not important that they go to school. It's good, but it is important to graduate. So, whatever gets in their way of graduation, childcare, transportation, whatever the reason, tell us and we'll fix it. Just stay in school. Just graduate.

We also look at optimizing the use of the GI bill. So, we advise the warriors on how to best use their GI bill so they don't burn through it and end up not completing the degree. We sort of pace it out.

We had a VetCorps volunteer that worked for me that did a great paper on that and showed the benefit, the economic benefit, too, to the schools, why it was smart.

Reduced homelessness by 70 percent. You can see the unemployment.

And then, what we think is that this year we will touch 40,000 post-9/11 veterans in the community, in the country, through this. The next year we look to double

that.

The model that we have is as applicable to little Clinton, New York, where I grew up, which has got 2400 people in it, as it is to Boston, Massachusetts. It just works. It is somebody who is the honest broker in a community who can connect people to resources.

In terms of the questions you had, I wrote them out and I didn't include them on the slides. But what type of services will the current generation need long-term? In my opinion, understanding of opportunities, because they don't know what they don't know; navigation of the system, because it's not what you know; it's who you know, and access to the services. How do we increase the access?

No. 3, how prepared is DoD and the VA to care? What I see locally, it breaks my heart. When I see a family and they have to uproot themselves to move to San Antonio or to

move to Washington, D.C. or to move to a site where they can get DoD or VA care, when they could actually fee-for-service, they could stay in Augusta and get it at the Medical College of Georgia or the facilities that are there.

Basically -- and I'm a nurse by trade -- I always believe that the best care is provided by the family. If you can keep them close to their family, that is almost as good as having good quality care.

And then, what could our community organization do? The same thing that we do at colleges and universities. Hospitals can take care of them. We'll take care of all the other stuff in the area.

What interferes with transitioning? And I'm going to read this. "The blind limitation of the joint ethics regulation. The joint ethics regulation provides little room for JAG interpretation when a Commander seeks gray area, and when

gray area is identified."

So, when gray area is identified, programs are inconsistent across the Services. What happens is, if I go to Tacoma, they have a different interpretation than if I'm at Ft. Gordon, than if I am at Charleston Air Force Base.

And the Commanders, while they want to work with you, they look to their JAG. And if the JAG can't find any interpretation, it's not happening.

Our goal as a community is to improve Ft. Gordon, is to improve the services that they provide, to make them better. It's to make the VA better. But I can't do it without partnering with them.

And the joint ethics regulation prohibits me from partnering with a federal entity. And so, I would say that is probably the biggest obstacle that we face that I have seen.

How can DoD improve the transition

services? Communicate with community programs.

And I will tell you, I sat through the TRO brief. I didn't even know that they existed. But we could leverage our community resources extensively if we just could communicate with the people who provide the services. It becomes so stovepiped. The one group that we can't collaborate with, DoD and the VA, because it is a very closed system. Figure out how we can open it up.

And then, how are our activities going to change? They're not going to change a bit. We're going to keep doing what we do. We support all services, as I said.

Any questions?

CO-CHAIR CROCKETT-JONES: I think we're good.

Denise, anything?

Okay. Well, thank you very much. It has been very helpful, and I think that you've really got a handle on the real

population. So, thank you very much.

DIRECTOR DAILEY: Thank you, gentlemen.

This concludes the Task Force's activities for this business meeting. We will see you again in February, late February, and we'll be in touch between now and then for your installation visits.

Thank you.

(Whereupon, at 4:30 p.m., the meeting was adjourned.)

W

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: January Business Meeting

Before: Task Force on Recovering Wounded

Date: 01-28-14

Place: Arlington, VA

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter